

Public Administration and Constitutional Affairs Committee

Oral evidence: [Public and Health Service Ombudsman Annual Scrutiny 2016](#), HC 809

Tuesday 13 December 2016

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Members present: Mr Bernard Jenkin (Chair); Ronnie Cowan; Paul Flynn; Kelvin Hopkins; Dr Dan Poulter; Mr Andrew Turner.

Questions 1-98

Witnesses

I: Scott Morrish, father of Sam Morrish, Keyna Doran, PHSO the facts, Della Reynolds, PHSO the facts

II: Dame Julie Mellor, Parliamentary and Health Service Ombudsman, Amanda Campbell, Chief Executive Officer, Parliamentary and Health Service Ombudsman

Written evidence from witnesses:

- [Ms Keyna Doran](#)
- [PHSO the facts](#)

Examination of witnesses

Scott Morrish, father of Sam Morrish, Keyna Doran, PHSO the facts, Della Reynolds, PHSO the facts

Q1 **Chair:** May I welcome our witnesses to this pre-evidence session on the annual scrutiny of the Public and Health Service Ombudsman. Could I ask each of you to identify yourselves for the record, please?

Scott Morrish: My name is Scott Morrish. I am Samuel Morrish's dad and I have had two complaints go through the PHSO.



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Q2 **Della Reynolds:** I am Della Reynolds and I am the Co-ordinator of PHSOthefacts, the pressure group.

Keyna Doran: I am Keyna Doran. I am also a member of PHSOthefacts but brought a case as an individual for a vulnerable service user.

Q3 **Chair:** Thank you very much. I am very sorry you are so far away in this very large room. We didn't choose the room. Also I don't want to make you feel that we are cross-examining you. We just want to get a flavour of where you think your experiences and the experiences that you represent are at the moment. Can I ask each of you to summarise your experiences with PHSO?

Della Reynolds: I feel I am representing a number of people, all the members of the group. What I have done is rather than look at my own case, I have identified three key areas that are common among all the group members. The first of those is bias. We consider there is bias towards the public bodies that have been investigated and in that respect the Ombudsman is serving to defend them instead of defending us, the public. There is a lack of transparency in the process due to the privacy rules and particularly around clinical advisers. Many people are very upset about the transparency on clinical advisers as the clinical advice is often used to close the case. Finally, a lack of accountability; when we have a complaint when we say something is wrong, it goes nowhere. There is no one we can complain to, effectively.

Keyna Doran: As I say, I am a member of PHSOthefacts, so a lot of the problems I have experienced with the PHSO sit very well with other members. I went through the entire complaints system. I am now in year 7 after one single trust failed somebody in safeguarding problems. There is not one part of the system that works. When you get as far as the Ombudsman you really do have an expectation that things will be taken more seriously, like when a trust has broken the law, when it has failed to abide by its responsibilities, legal and otherwise, safeguarding of patients, and that didn't happen. There were clear cases where the trust broke the law; they abused the Mental Capacity Act. It could have been looked at very easily by the Ombudsman, the point being that they broke the law purely to avoid answers to our complaint. Not only did they break the law to do that, because they have no right to stop a service user from complaining, unfortunately they breached her human rights and left an extraordinarily vulnerable person without any advocacy whatsoever. I was her advocate. The Ombudsman should have looked at that but rather than doing that they split the complaints into two and also precluded me from advocating for her. There is a lot in the report about vulnerable people and how incapable, unable they are to speak up for themselves and we have been precluded.

Scott Morrish: I have had two complaints go through the Ombudsman and have had a more positive experience in the end than many people are fortunate to get. Both complaints were upheld in the lion's share of the details, but there are common patterns that I would not say are



unique to the Ombudsman. They are unique to complaint systems throughout the system, probably way beyond health but my experience is only in health. They include that people can be left with an impression of bias and the lack of accountability for the quality of what is done rather than the timeliness or the cost of what is done or the numbers of investigations that are conducted. That creates a vacuum in which so many wrongs can be hidden. A lot of mistakes just go unnoticed because families, quite reasonably, get to a point where they cannot carry on. It takes a huge amount of effort, a huge amount of determination and a real bloody-minded stubbornness, if I am honest, that most people should not be expected to have.

I don't believe that the system is a conspiracy. I think it is just quite poor. I can see evidence that some of the things that have been wrong are now being understood but I think there are some fairly significant steps that are going to need to be taken in order to make sure that they are properly addressed rather than us just describing lessons that have been learnt.

Q4 **Chair:** How much do you think all these problems that you identify with the Ombudsman are in fact because the Ombudsman sits at the top of a very inadequate complaints handling process in the health service? This morning we have the CQC's pretty stunning report that demonstrates that they could find in no single trust any comprehensive investigation, candour and learning from mistakes. Aren't we setting the Ombudsman an impossible task to be the rectification of all this huge problem in the NHS?

Scott Morrish: It is not purely the Ombudsman's responsibility but I think questions should be asked about why it is a shock for the CQC. Where have they been for the last five, six, 10 years?

Chair: Sorry, say that again. Where has—

Scott Morrish: Why is it a shock for the CQC? They express shock that they can't find evidence of a trust doing this well. Those of us who have tried reasonably to go through the system know full well that most of the people involved are good people but they are not being empowered, equipped, resourced, being allowed to do what needs to be done. They often know that the investigations are inadequate.

Q5 **Chair:** How much do you see evidence of learning at the CQC, even if it is "at last"?

Keyna Doran: Absolutely none, in my experience. I have tackled the CQC on various issues. For instance, their inspections of mental health services, which represent a huge proportion of very vulnerable people who have no representation whatsoever, are wholly inadequate. They don't hold listening events prior to inspections of mental health trusts. They gather their evidence from places like PALS, Healthwatch and the CCGs. None of them is identifying trends and themes in complaints and it is only when the coroner then flags it up, albeit that suicides are hugely



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underreported. That is why Southern Health and none of these massive scandals that have come about will ever be addressed because nobody—and I mean nobody—is identifying trends and themes in complaints in terms of failing trusts.

The whole system passes responsibility to the Ombudsman, so even if it is something you have complained about that is a systemic failing, say, to the Department of Health, they will say, "Take the complaint to the Ombudsman". You say it doesn't form part of your complaint because it only became apparent as you were going through the complaints process and there is just this mantra, "Take it to the Ombudsman, take it to the Ombudsman, take it to the Ombudsman" and they don't look at complaints of individual people. They say it proudly, "We don't take on the case of the individual". Until some of these organisations do start taking on the case of the individual, we are not capable of saving lives in this country.

Della Reynolds: There is no incentive on the trusts to resolve the complaints at the first stage. They can take as long as they like, and they do, so they string it out for a year or more.

Keyna Doran: Four and a half years in my case and then they broke the law.

Della Reynolds: Then they pass you to the Ombudsman. They know that the Ombudsman is going to string it out for another year and probably uphold a partial complaint and not something major. There is no kind of carrot and stick to ensure that the trusts deal with it in a timely manner at the first stage. In Scotland you can go to the Ombudsman after 20 days. You don't have to wait for closure and in Scotland the Ombudsman has powers to instruct the trusts in good complaint handling and enforce it. In our Ombudsman system we don't have that. You can't go to the Ombudsman until they have finally given you that closure letter and then the learning is too far down the road. Then all we have is the powers of recommendation: the Ombudsman can recommend. It is toothless. It is too weak.

Keyna Doran: The Ombudsman could remedy that very easily by telling trusts that they are not to recommend that complainants go to the Ombudsman unless it is in the final letter that they send to you that closes the complaint down. As I said, in my case it was four and a half years and they kept saying, "Go to the Ombudsman, go to the Ombudsman", so I did and I was told, "It is too premature because they haven't answered your questions". I did get maladministration against the mental health services in Gloucestershire and service failure for complaint handling and there is a new 44-page complaints procedure document put in place. I have said, and I mean this wholeheartedly, if at the end of the day a trust can break the law and abuse the Mental Capacity Act, what good is a new complaints procedure when they just turn round and say, "We are not going to answer your complaint because



the person doesn't have capacity to give her permission to do that"? That was a lie.

Q6 Chair: I understand that. Just picking up one other point that you raised, Della Reynolds, about secrecy and the confidentiality. As you know, we have recommended a complete overhaul of the Ombudsman process and we have also recommended a clinical incident investigation body to investigate clinical excellence in the NHS. In both cases we are recommending that there is an element of confidentiality, a safe space to speak. How much do you recognise that that is an important element of any open and trusted complaints system?

Della Reynolds: I can understand the principle of the safe space. Unfortunately it is misused to effectively keep the complainant out of the investigation. What happens, and this happened in my case, is the body that I complained about provided evidence to the Ombudsman that I was not able to see. I provided my evidence. When the case was closed I was then able to see the evidence provided by the body and found it was full of inaccuracies, some downright lies or just omissions, which gave a completely skewed account of the circumstances. If I had been able to see that evidence before the decision was made, which in 2014 you asked Dame Julie Mellor, "Can you do that? Why don't you just show them the evidence before you make the decision?" and the response was, "Yes, we're going to do that. We will do that" but they haven't done it. The reason they don't do it is they say, "The legislation says the investigation has to be in private and we can't share this with you". That keeps the complainant out of the investigation process and delays the whole thing because it is really too late when you are trying to put it right at draft review stage, at draft report stage. It is too far down the road.

Scott Morrish: One of the things that has struck me as odd all the way through my five, six years now is that there is all this talk of transparency and openness. It is in guidelines; it is spoken about regularly. In that case, why do we have a complaint system that conducts its complaints completely behind closed doors? If you want to model openness and transparency—accepting that in some cases there are very good reasons for something like a safe space in a particular context and used by particular people—in general the assumption should be one of openness and honesty. To tell a complainant, somebody who has been forced, in many cases, to try to address grievances by going into a complaint system that they quite often don't want to do anyway, that they can contribute evidence to it but see nothing in return until you get a report at the end of it that may or may not be misguided, seems to set the wrong tone for the whole system. If you want to lead by example—and I would suggest that anybody at the top of the complaint system should be doing that—that needs to be addressed as a matter of urgency. Along the way you will also address issues like bias and competence and the holes that many of us think exist in these reports. It would come to light much earlier and then it could either be addressed or, if it isn't, you have different grounds for proceeding with your concerns.



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Q7 **Ronnie Cowan:** Can I ask you, Mr Morrish, how did the PHSO deal with your complaint? How did you feel it responded to your concerns?

Scott Morrish: I would like to put one thing on record. I was very critical of some aspects of the report of the first investigation but the investigator who did that for us pretty much did it on his own. It was quite remarkable for somebody to manage to do what he did do with the other caseloads that he had at the same time. It is not about the individuals involved but I felt that the process failed to deliver a common sense approach to what was obviously an avoidable death that had been missed by the NHS itself. I would expect anybody who is tasked with an investigation, if they find a death that has been classified as unavoidable and it then turns out to be avoidable, to try to find out why that was but also why the NHS failed. That is pretty much the basis for the second investigation report.

Q8 **Ronnie Cowan:** How did the PHSO deal with your concerns when you raised them?

Scott Morrish: The second time round on a completely different footing. I feel as if I probably had more attention and a better service than most other people that I come into contact with. I suspect that is partly because it became a public case. I would like everybody who has complex cases and serious concerns to receive that same attention and attention to detail.

Q9 **Ronnie Cowan:** To the representatives of PHSO the facts, how do you feel the PHSO engages with you?

Della Reynolds: In my case, and it is quite common among other group members, what the Ombudsman does is say they have to find harm caused by maladministration. They look at what should have happened and what did happen and try to see if that was maladministration that then caused harm. I delivered to the Ombudsman, in the first instance, a lot of statements from policy documents, some statutory policy documents, and it was all dismissed as lacking subjectivity. What actually happens is when you give evidence that policies and guidelines such as GMC guidelines and NICE guidelines have been breached, the answer comes back, "They are only guidelines. That is not maladministration that they have been breached". When you supply evidence that the law has been breached, statutory policies have been breached, then the answer comes back, "But we are not a legal body. We don't make legal decisions". When you are looking at what should have happened surely you have to use the policies that guide the practice. In fact you go through all these policies—I have read more policies than I ever want to—and you take out all the examples. All of us here have dedicated our lives to following the complaint process, believe me. You take out all the clauses, you write them all down and you give your evidence that they have been breached, just to be told, "Well, they are guidelines; that is not maladministration" and that is very disappointing.



Keyna Doran: Then the clinical advisers and the Ombudsman use the guidelines to support the case at the trial but equally, when there is evidence within those guidelines that supports the complainant, they are completely—and I mean completely—ignored. They cherry-pick NICE guidelines; they cherry pick which guidelines. I have no clue what the Ombudsman means by comparing what happened with what should have happened and I think anybody who has complained to Ombudsman doesn't have a clue what that means. We would have thought NHS constitution, NICE guidelines, clinical guidelines, evidence-based policies. I wrote at draft finding stage and asked that question and the Ombudsman replied, "You say that we failed to consider a number of guideline standards, legal requirements and human rights breaches when investigating your complaint. It is for us to decide which standards are most relevant when investigating complaints. That is what we did."

Nobody in their right minds would take a complaint—after seven years this has been going on—to the Ombudsman if they knew that the relevant standards that we believe you should adhere to as a trust or a healthcare provider or any other organisation were going to be completely disregarded. I would not have wasted 21 months with a complaint at the Ombudsman and it precludes all of us, 90% of us say, from then taking another form of action because of time constraints. Sorry.

Q10 **Ronnie Cowan:** No, this is your opportunity absolutely. The big question is: what should the PHSO do to improve the service it provides?

Scott Morrish: I think we need to decide or you need to decide what you want the Ombudsman to do. If you want it to judge complaints and deliver a judgment then you will get one kind of Ombudsman. If you want an Ombudsman that is going to look at complaints and look for learning you are going to need a slightly different process, a different methodology and you will end up with something different. I would argue it would be more useful for everybody. But at the moment I think we are stuck in a situation where its roots are way back in the past. The Ombudsman was set up to do something. I think needs and expectations have moved on substantially and the Ombudsman has not kept up. If we could move away from just focusing on a judgment that basically is either going to clear or shame someone and start looking primarily for learning and reserve judgment when that is needed, quite rightly, then you would conduct your investigations in a different way. The habit of comparing what is documented to have happened with what should have happened is in itself fraught with dangers because it assumes the guidelines were good and it assumes that they have been understood. There is a whole raft of other things that happen in a complex, high-pressure situation where lives are in the balance that go way beyond guidelines, and it is the culture that we have talked about before. If you want the Ombudsman to deliver learning and improvement in the system in the whole, make that its task and be clear that that is what you are asking it to do.



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Keyna Doran: Can I also add that with the clinical advisers being asked for advice, obviously they are used because the investigators don't have the necessary experience in clinical roles but then they are asking the questions of the clinical adviser rather referring the questions to us. That is an absolutely key thing because the questions in our case were reduced, narrowed and totally irrelevant to what the main body of the complaint was. I am not quite sure how an investigator who doesn't have a clinical background should be the only person who is asking the clinical adviser questions that don't fit the complaint.

Q11 **Chair:** When you refer to "us", you mean the people who are complaining?

Keyna Doran: Us, yes, the great unwashed.

Q12 **Chair:** It comes back to this point that complainants don't feel sufficiently involved in the investigation?

Keyna Doran: No, not at all. We are not even told what evidence we can supply with our complaints. As the investigations progress we would expect to be able to add extra evidence, certainly at draft finding stage when you find out that so much has not been included. You offer this evidence because it would support your case and it is refused, so it is far from being an impartial investigation. I think other group members have found that too.

Della Reynolds: If I could answer the question on how can it be improved, I think it comes back to Parliament because Parliament set up the Ombudsman in the first place and Parliament now has a golden opportunity after all these years with the new Public Service Ombudsman Legislation going through the House. I have had a read through it, there is very little difference in that document from the original legislation, it is still full of total discretion for the Ombudsman, privacy of investigation process. I think we need to grasp this opportunity now in Parliament because it seems as though this Committee on a yearly basis ask the Ombudsman to improve, the Ombudsman then asks the trust to improve, it is all going down the chain, but that has been going on for years and nothing has improved. So that is clearly not a model that is working. What we need is for Parliament to take this opportunity with the new legislation, and what I think is important is that the Ombudsman gets involved earlier. If there is learning it should not come three years down the road or seven years down the road. The Ombudsman needs to come in much sooner. So the clause that says you cannot go to the Ombudsman until your case is closed, that has to be reconsidered.

Q13 **Chair:** That is what happens in Scotland?

Della Reynolds: You can go to the Ombudsman after 20 days in Scotland. You can approach the Ombudsman. You can approach the Ombudsman here but they will simply say you are too soon and send you away again. Then, I think, we need to look instead of at full investigations, which are very expensive and also very lengthy and put



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great pressure on everybody, the complainant and the trust or the person being complained about. They are also suffering through those lengthy complaint investigation procedures. I think we should go for something much quicker and look at alternative dispute resolution measures, and use the Ombudsman to provide a mediation service. Some people will require a full investigation, that is absolutely the case, but many people could get much quicker resolution at that early stage through mediation. Mediation effectively saves space because the rules of mediation are always total confidentiality and it cannot be used in court. So you have that built into the system.

Q14 Chair: Thank you, you have answered the last question, which was what you think of the PHSO Bill that has now been announced and I would invite the PHSO the facts and any other organisations to send us your views about that and your considered comments about what needs to be changed in that. This Committee may or may not be doing the pre-legislative scrutiny of that Bill but we will certainly make sure the points you advance are taken into account.

Finally, you have been very restrained towards this Committee about what you might feel about the way this Committee has conducted its scrutiny of the Ombudsman over the years. Is there anything you would like to add to that?

Scott Morrish: Yes, I think the fact that we are here today is very heartening from my perspective because it has been deeply frustrating over the last few years watched scrutiny sessions thinking, "These are the wrong questions, why aren't you focusing on these areas?" The lynchpin to a good investigation is knowing that the quality of what is in the final report means something and answers the questions that triggered the complaint. That is the single thing that has been lacking. You have looked at the finances of the PHSO, you look at the numbers of investigations that it conducts, you look at the time each investigation takes but the quality of investigations has never been looked at and you can only know that if you don't just take the PHSO's word for what is in that final report but you also have some mechanism for knowing what the families involved and the staff involved think of it. Obviously this is an area that falls outside your immediate remit but this is where the CQC and NHS Improvement and others have a huge role to play. It is that vacuum at the moment that allows the systems to fail. Address the leadership in those areas, get the processes and the structures right and the culture will follow. But until you have done that we are going to have lots more sessions like this.

Keyna Doran: We are all sitting here knowing full well just how much money is being wasted in the system. There are some 70 organisations between the complainant, the NHS Trust or whatever and the actual Ombudsman. Poor quality care costs a lot of money, and certainly in mental health services it costs society as a whole an astounding amount of money. I would like to cite an example, if you don't mind. All of your organisations, CQC, PHSO, are all writing reports about each other, no



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one is looking at the whole picture and saying, "If PALS fail, Health Watch fails, the CCG has failed, the CQC fails". If anyone of those organisations worked and did what they say on the tin then we would not be going to the Ombudsman because we would be having our complaints resolved at local level, which is indeed how it should be. But to not resolve them when somebody is still alive but being subjected to a level of inhumanity that I have never witnessed in my life before and there was not one organisation that stepped forward and said they could do anything. So now this person would have died had the police not been there.

I have to recommend Gloucester police force in this instance and the ambulance service, because had they not intervened all the times that they did she would be dead. How many more people have to die as part of the system that is failing before somebody somewhere gets it that it has to be looked at globally. The safeguarding team, nothing from them. CCG, nothing. "Oh, go to the Ombudsman. Go to the Ombudsman". Because it is so serious I just want to give you an example. This is one person who had a very stable and okay life and in a three-year period she had six ambulance call outs, which to a large extent you would think is quite a lot but with a profound mental health problem that isn't. The trust made a minor change to her care plan and in the following three years she had a 283% increase in ambulance call outs, a 1,900% increase in hospitalisation—which does not include self-presentation to A&E and non-scheduled, scheduled admissions into psychiatric hospital—she had an approximately 900% increase in police callouts and a huge increase in reliance on her GP and practice nurses. At no point during the system could I stop any of that from happening. So she was arrested, she was sectioned, she was subjected to face down restraint, she was sent home to her house where the noose was still hanging from the skylight an hour and a half after she hung herself. The trust said she was attention seeking when she hanged herself. Nowhere, nowhere, did the system help me.

Seven years on, I am ill, she is ill, she is not getting good care, other people are not getting good care, this trust that I am talking about that the Ombudsman was fully aware with, doesn't even provide treatment for her diagnosis and yet they say they do. The Ombudsman doesn't even look at it. They just say, "Follow NICE guidelines". I could absolutely 100% guarantee you why I know that these scandals of people dying in this country are happening and I recognise everything that everybody is saying and it does not help all these unnecessary deaths and then they are unreported.

Chair: Thank you. Della, do you want to have the last comment?

Della Reynolds: Yes, I do. Keyna is right, there is no humanity in the system. There is not a drop of humanity. You are a number, you are processed through it and I think in terms of this Committee obviously your inability to scrutinise individual cases leaves us high and dry because the things that we are telling you about now you could see if you



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were to look into the investigation files but you are prohibited from doing so. I think again in the new legislation we need to change that. Whoever is the scrutiny committee for the Ombudsman has to be able to scrutinise, as Scott said, the quality of the investigation process. That is the thing that we are all complaining about. So I am hoping that that could be added.

I was very disappointed to read that Chris Skidmore stated when the new legislation came out, "The measures in this draft bill will ensure that anyone who makes a justified complaint can expect rapid effective remedy and that their voice will be heard." I felt that this was very irresponsible. He is just completing raising false hopes among people when you go to the Ombudsman and you think that is what will happen because it does not happen. There is a regulatory gap, thousands of cases are dismissed without even an investigation because the Ombudsman doesn't have the resources, and won't in the new Ombudsman format, to investigate every case. I think it is really irresponsible when politicians put that out in the public domain.

I would just like to read this tiny letter. This came in as an e-mail to me. I run the pressure group, I get people contacting me every week with their concerns and given that we have heard that there is so much improvement in the Ombudsman service, this one just came on 7 December, and she says, "So pleased to come across your website, discover I am not going mad after all. Currently drowning in the process, have had complaint partially upheld but banging head against a brick wall with the part of my complaint that mattered to me and traumatised me the most. It is the single biggest sadness of my life that I can't seem to get justice, despite fighting so hard for so long. Have already complained they don't follow their own service charter and evidence ignored, but I am going around in circles." Now, this person is an academic and a university lecturer. Communication is her core skill and she is unable to be understood by the Ombudsman. So what is happening there?

Q15 Chair: Thank you very much. One thing that we have innovated is that we listen to individuals and organisations like yours in order that we better understand what customers of the Ombudsman are feeling. What complaints the Ombudsman are feeling and experiencing. We are very, very grateful for your evidence and I hope we will continue to work together. Thank you very much indeed.

Della Reynolds: Can I just ask if we can have a meeting with you, Mr Jenkin, and any of the other Committee members with members of the pressure group at some point?

Chair: The answer is yes.

Della Reynolds: Good thank you very much.

Keyna Doran: I think it is imperative because people are dying and they continue to die, so this is going to happen again and again and



again. Everyone is fully aware of how it is happening. Sir Robert Francis's report amply covered lots of areas that we have been saying. The report is written in 2003, again we are seeing the same old, same old thing but if there is no provision of services for a very high-risk service user group, which they are, they are relying on the charity Suicide Crisis. There is no provision and we have high suicide rates in Gloucester, very high.

Chair: Thank you very much indeed.

Examination of witnesses

Dame Julie Mellor, Parliamentary and Health Service Ombudsman,
Amanda Campbell, Chief Executive Officer, Parliamentary and Health Service Ombudsman

Q16 **Chair:** I apologise that you are so far away; we didn't choose the room. Could I ask each of you to identify yourselves for the record, please?

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

Amanda Campbell: Amanda Campbell, Chief Executive.

Dame Julie Mellor: Perhaps I could say one other thing in introduction, because Amanda has been with us I think all of 45 days and so it may well be that we will need to double hand questions, whoever they are asked to, because there will be things I know from the past that Amanda might not yet.

Q17 **Chair:** Welcome, Amanda, to your new role. Can I also say we have just heard what a challenge you are facing and the CQC report, our own reports on complaint handling, our own recommendations for a new investigative body to do clinical incident handling, all underlines the enormous pressure that PHSO is under and increasingly under because of the deficiencies of dealing with complaints in the NHS in particular. Obviously we have the new legislation but that is not going to solve the immediate problems and, indeed, there may need to be changes to the legislation to ensure that it does solve the immediate problems.

I am also aware, Dame Julie, that you have tendered your resignation and you are only remaining in your post because you wanted to give us time to appoint a new Ombudsman and we are in that process. Therefore, you are not overstaying your own welcome, you are continuing to serve the role to which Parliament appointed you until Parliament discharges you from that role because we have replacement. If you did not stay in your job, there would not be an Ombudsman at all until we could appoint a new one. So we are grateful.

Q18 **Mr Andrew Turner:** In your annual report and accounts you say that the head of internal audit at PHSO suggests the implementation of recommendations is generally slow and that some recommendations remain unaddressed. Why is this?



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Dame Julie Mellor: This is in relation to audit report recommendations?

Mr Andrew Turner: Yes.

Dame Julie Mellor: I think the context for this is that we realised at the beginning of the year that this annual report applies to our accounts had qualified in the prior year and so we recognised the difficulties that we were facing. We took stock and embarked on a plan that will take us through to the end of our five-year strategy plan. The accounts had been qualified, we had had significant turnover in our senior staff, and in fact all four members of the executive team are new within the last year. That has had a very significant impact upon what we could operationally.

We were also aware that we were facing rising demand, 24% comprehensive spending review reductions and a lot of our ways of working were tied to the past where we were doing 400 cases a year rather than 4,000. So we took stock as a board team and came up with a programme of activity. We now have a stable executive to take things forward but obviously we have to prioritise. So in relation to the question that you have asked, in fact in February we have asked our audit committee to look at all of the outstanding recommendations from our audit report and agree the prioritisation of action for those so that we can deliver those recommendations in a managed way.

Amanda Campbell: I agree that it is not the right thing to have audit recommendations outstanding for long periods so following my arrival I asked for one of the executive team to take responsibility for going through all outstanding recommendations and coming back to the executive with a proposal for how we would move through and resolve those recommendations more quickly. Because some have been outstanding for a long time and we have been making a number of changes to the organisation, some may have already been resolved, partially resolved, other may not still be applicable. So by asking one of the executives to take responsibility and do a comprehensive review of all outstanding recommendations it means we can now start to resolve them and move forward.

Q19 **Mr Andrew Turner:** When will that report come back to you?

Amanda Campbell: I am expecting it to come back to me towards the end of January.

Q20 **Mr Andrew Turner:** The head of the internal audit has given the PHSO the second lowest level of assurance on the overall adequacy and effectiveness of your governance, risk management and control, what are the reasons for this?

Dame Julie Mellor: Again, if I can start. In 2015-16 we asked our auditors to review all our financial processes to inform the improvements that we wanted to make following the qualification of the accounts so that we knew that our action plans were then comprehensive and robust. In that sense it is not surprising that some of the assurances were lower



than we would like but it meant we could develop robust plans to deal with the issues.

Amanda Campbell: We took a decision prior to my arrival that getting the financial side of our governance right was the priority. With the help of some external support we have created a new finance code, we have gone through individually all 150 finance processes and created a new finance manual and are now operating in accordance with those new processes and conditions. I think you will see that the accounts this year, for the last financial year, have been accepted and the National Audit Office has commented that there has been a significant improvement in the governance around the financial processes of the organisation.

We are now making inroads into the other parts of governance, because it is not just finance. So we have a new strategic risk register. I have again commissioned some work to look at how we can develop that further. I am very interested in how we can make risk management just something that is throughout the organisation as part of its culture as opposed to a risk register that is managed. I have had a positive conversation with the NAO about that and about what we might do quite differently. I think what the audit reports show is that there has been real progress in some areas. So whereas a partial assurance some time ago, when we have gone back again and looked at finance there is now significant assurance and that is the model that we are hoping to follow. We have had two internal audit investigations this year, one on our casework processes and assurance and we have significant assurance against that. So I think there is progress but there is a lot still to do.

Q21 **Mr Andrew Turner:** What is being done to facilitate a swift and more effective response to issues raised by internal audit?

Amanda Campbell: I think that comes back to what I was saying earlier about the review that I have commissioned. What we need to do is move through all of the outstanding recommendations and get on top of those, understand why they have been outstanding and resolve them more quickly, and then put in place processes to make sure that as recommendations come forward that we assign those to individuals to take ownership and to make sure that they are actioned, not simply put on a list that we come back to from time to time.

Q22 **Ronnie Cowan:** We have just heard that implementation was generally slow and also there were delays in the publication of the annual report and accounts as well your main and supplementary estimates memoranda. From the outside looking in I presume nothing happens swiftly with the Ombudsman. I hear what you are saying, Dame Julie, you are leaving and, Ms Campbell, you have just joined but it goes back to what was previously reported, it just goes around and around and around. Three, four five years from now we will still be in the same situation and people will be talking about we are planning to put in better processes, we are looking at this, there is absolutely—the word that was used earlier—no humanity in this process. At what level in the structure



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does that humanity kick in and we stop looking at spreadsheet management and start looking after human beings?

Dame Julie Mellor: Sorry, I was hearing two different things there. One was about the lateness of the annual report last year but the other was, I think, a much broader question about the service?

Ronnie Cowan: Yes, the focus seems to be, as used there, "Our priority is financial governance".

Amanda Campbell: The priority in relation to the governance. The question was about governance and I said that our priority, because of the qualification of accounts previously had been to get on top of the governance of our financial business and that is, in governance terms, what we have prioritised.

I completely agree that this system is all about justice for individuals, for people, and humanity has to be right at the heart of that. So one of the things that I have been most focused on since my arrival is about how long people have to wait to go through the processes in our system but also how long they have to wait in the lead up to being referred to us and coming to the Ombudsman. So when we talk as a management team, we are talking about the people, we do not talk about the cases or the numbers, we talk about the individuals that are having to wait, we are talking about how long each individual case has to take to go through our system because our aim is to try to bring those numbers down.

We have really good evidence that even though there have been clearly a number of issues in the past, over the past six months, over the course of this financial year, we are seeing real progress. So cases being resolved in much quicker time than previously and then the numbers in this report. It is a journey and we only at the start of that journey but I think what we have shown now is that we are starting to show the rises that everybody on this Committee would want to see.

Dame Julie Mellor: If I can add on your specific question about governance and the annual report then, yes, we published later than we had published before on this annual report. That was with the advice of the NAO given that the accounts had been qualified and wanting to make sure that we had been able to make progress on the financial management arrangements, which we did, which is why the report that is published showed a clean audit, no qualification of accounts.

On humanity, I know, Mr Cowan, that you joined this Committee during the period since I became Ombudsman and I would say in terms of our ambition to be much more people focused then I think we have made good progress in having more impact for people who have been let down when public services fall short. I certainly would not say that that has been delayed. Amanda has given some specifics, perhaps if I can just paint the bigger picture of what we were setting out to achieve and what we have.



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We opened our doors in 2013 to the public where we had done 400 investigations a year before, costing roughly £88,000 per investigation, and we didn't think that was value for money for the public or the taxpayer so we opened our doors, we are now getting justice, getting things put right, for five times more people in half the time. I wanted us to be a much more people focused organisation and so we have invited critics like PHSO the facts, other organisations, individuals and people who use our service in to help us work out what will give them confidence in our decisions and we have produced a service charter that we launched this year, which is best practice in terms of the things that matter to people, that is now our quality framework and that we are now measuring and that is why Amanda can talk about the things that have started to improve.

The other big thing that we have done—

Q23 **Chair:** Could I just stop you there? We are going to come to some of these questions later on.

Dame Julie Mellor: Okay, fine.

Q24 **Ronnie Cowan:** I went slightly off piste there. It should have been financial management and I let my emotions run away with but I don't think that is such a bad thing with what we are talking about here.

Dame Julie Mellor: I like that, that is fine.

Ronnie Cowan: What are you doing to ensure that next year these reports are all delivered on time?

Amanda Campbell: We have been talking to the National Audit Office about the planning for laying the accounts for next year. As we talked about, we were much better this year but we are not at the standard that we would say is excellent so we are working towards that. We want to be able to show some best practice in terms of our financial management.

We have to book the time for the NAO to come in and do the audit of our accounts and we want to do that at a point where we can be confident that everything is going to be to that very high standard. We are working and talking to the NAO at the moment about whether we should do that immediately after the summer recess so that we can be totally confident but that we run into the summer recess to make all of the preparations so we are ready before but we do not book the NAO to come in and do that accounting process before the summer recess because then that would be the hard cut off deadline and we want to be as good as we can possibly be.

Q25 **Chair:** You are losing your interim finance director, what operational issues will that raise?

Amanda Campbell: We have been recruiting a permanent finance team, a team of six. We had previously all interim staff; we now have five of the six already in place as permanent. The final appointment, the permanent



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one, was made last week. The interviews were last week and the interim finance director will remain in place until the permanent director is in place.

Q26 **Chair:** So how many of your financial team are now full time?

Amanda Campbell: So five full time permanent members of staff and the sixth member of staff—

Q27 **Chair:** What proportion of your team is that? How many are still part time?

Amanda Campbell: No, sorry, so we had interims and permanent members and at one point they were all interim members of staff. So not permanent members of staff of the organisation, now five of the six—

Q28 **Chair:** So you have no temporary staff in your finance team anymore?

Amanda Campbell: One, the finance director is interim but the appointment was made last week for the permanent, but obviously that person has not arrived yet.

Q29 **Chair:** You have only just arrived and it may be an unfair question to ask you but maybe you could just give us your opinion. Why do think this has all taken so long to get a permanent financial team in place?

Amanda Campbell: We made a decision some time ago, prior to my arrival, that we would relocate the heart of the corporate services in Manchester. So we have been recruiting the new permanent team into our accommodation in Manchester. That is, I think, what has taken the time, moving the base from London up to Manchester and finding a new team and putting them in place. But the interim director has been with us for some time, he has been doing a very good job and is going to stay with us until we have our new permanent appointment.

Q30 **Chair:** So in answer to Mr Cowan's question, you think the permanent team now in place will avoid the need for the kinds of delays we have seen and accounting problems you have had?

Amanda Campbell: I do, yes.

Q31 **Kelvin Hopkins:** You have touched on accounts and what you have done so far but I will ask the question anyway. Following issues in last year's accounts you said you would implement a rolling 12-month cashflow forecast to address the issues with cash management. Have you followed up on this commitment?

Dame Julie Mellor: Absolutely we have. In fact, I meet monthly with our executive director for finance and governance and go through all the controls. There are five of them. The two that were qualified last year were to do with provisions and cash so there would have been a particular emphasis on making sure that we have done a complete pulling apart all our provisions, information and putting it back together so the assurance is robust. In fact my finance director was telling me this



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morning that we have cash in the bank of £1.1 million and that is monitored on a daily basis. So, yes, we have dealt with that.

- Q32 **Kelvin Hopkins:** I will touch on the £1 million. You drew down £1 million at the end of the year that you did not need, why were you not able to forecast adequately your cash needs despite this increased forecasting?

Dame Julie Mellor: I am not sure what that particular one relates to. I may well be that we had put in some provision for redundancy during the year that would have come towards the end of the year and in the end it passed into the next year. But I am not sure if that was it. It may well have been.

Kelvin Hopkins: Perhaps we could follow that up next time. Thank you.

- Q33 **Chair:** Looking at the number of cases that you handle, it has now gone down in your 2015-16 report by 8% against the prior year. Why is that?

Dame Julie Mellor: Do you know, I think it will fluctuate year on year because we investigate what needs investigating rather than trying to hit a target of a certain number. So we look at all the cases that have had a response from the local body, that is about 8,000 of them, and we investigate around half of them but I think that will fluctuate depending upon whether we have found signs of maladministration leading to injustice that has not been put right or not.

- Q34 **Chair:** But this does not represent a decline your demand for complaints?

Dame Julie Mellor: No. No, and in fact in my time the number of people coming to us for information and asking if we would take on their complaint has gone up 20% to 30%. So, no, it is not a question of demand.

- Q35 **Chair:** So for some reason having decided to process many more complaints, the system then is processing fewer complaints. Should we conclude that you were biting off more than you could chew?

Dame Julie Mellor: In what sense?

Chair: Well, in the previous year maybe you were trying to do too many complaints.

Dame Julie Mellor: No, in fact this year we have completed 20% more investigations as of October than we had in the prior year. I honestly think you will get fluctuations and we shouldn't be stuck on a certain amount. Every ombudsman service will have some variation in the percentage of cases that they take on to investigate based on particular cases.

- Q36 **Dr Dan Poulter:** Just on that point, looking at those cases where there was a lack of satisfaction, do you analyse why that may be the case?

Dame Julie Mellor: I am really sorry, I am struggling to hear you.

Dr Dan Poulter: Sorry, I will speak louder rather than relying on the



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microphone. When you have had cases where you have investigated and there is a lack of satisfaction, do you analyse what the underlying reasons are for the lack of satisfaction in those cases?

Dame Julie Mellor: This is where our service charter comes in, which I am really proud of because it is where we have been consumer focused, as I was saying, in both the bodies and the individuals. We now have a quality framework that we developed with the people who use our service and it is based on what is called procedural justice. So what is it that gives people confidence in a decision? So our quality standards will include the kinds of things that you are asking about. It looks at what information are we providing people with, is the process robust and fair, how do we treat people and are we learning and improving. That charter we are now measuring each of those commitments to see how well we are doing and we will use that to decide where we still need to improve. So absolutely we do take the feedback that we get. One of the things about the charter again, as I am very proud of, is that we are triangulating the information we get. We have our internal quality assurance processes but also we get customer feedback against those commitments, and we have external reviews of the actual decisions. So we have a range of data that we can look at and we will be able to publish sometime in the new year for the first quarter that we have been able to measure against this new service charter, which is the September to December quarter. That data will be available to the Committee.

Picking up on one of the things that was said earlier about accountability for quality by your previous witnesses. That is something I feel very strongly about and I have proposed that in the new arrangements under the draft legislation that the scrutiny of this organisation does include looking at the quality of their service.

Q37 Dr Dan Poulter: Just to be clear, you have put in place a new process and you have your charter that you are now benchmarking yourself against, and we will be able to see the results of that process in more detail at future hearings. You are obviously benchmarking against an established charter and process that you have in place but sometimes when people have complaints and they are not satisfied with the processes as is, there is more than just benchmarking against a charter that would need to be investigated. What do you specifically do to look at and understand where there was a lack of satisfaction what the underlying reasons were and what processes you have to investigate that impact upon it?

Dame Julie Mellor: I think the measurement against the charter will help with some of that because you can see where people are less satisfied in the process and look at why and that then informs your improvement. But part of the assessment of progress against the charter is things like complaints about us, where people are not happy with the service or where people are not happy with the decision. One of the things that we have introduced in the last year or so, I think it came up at the last hearing, is a customer care team who won an award for the



best customer contact centre. We are very proud of this innovation and how well they are doing. They will listen to people's concerns and what they found is that very often by explaining the decision more people's concern goes away because they understand why that decision was made. If it looks like that there might be some flaw in decision then we will review that if there are new facts, factual inaccuracies or it looks like the decision is flawed then we can review and reopen cases. So that team's work provides us with a really rich source of feedback of the kind that I think you are alluding to, which then feeds into our quality assessment process and improvement plans.

Q38 Dr Dan Poulter: Just picking up a little bit about your annual report, which looked at your internal audit review and found that there are weaknesses in the reporting of performance, some inconsistencies in how the presentations to the board took place and perhaps a lack of executive tracking of KPIs. What have you done to ensure that the data you use measures performance in a more accurate and valid way in the future?

Dame Julie Mellor: Just to provide some reassurance, there is no question about the accuracy of the information that comes to the board. There was a specific thing in the audit that within investigations you start your investigation and you come out with a concluded investigation. There are some key steps along the way where there were some issues with the data accuracy but in terms of what the board look at, they would be looking at numbers of cases in and out and so the information the board received was accurate.

Q39 Dr Dan Poulter: I think one of the issues you picked up on was a lack of consistency in some of these processes and some of the reporting to the board, were you aware at the time there were some inconsistencies in these processes?

Dame Julie Mellor: No, I don't think it was inaccuracies to the board, that is what I am saying. That was the question we asked ourselves when we looked at the audit, because that was the question raised by the auditors, but the information going to the board is at a higher level. The information where there were some concerns about consistency or accuracy was within the operational data that the operational team would be using. That is just the same as a hospital trust; that is the kind of thing that the operational team would then be looking at to make sure they can improve it for the future for themselves so they can track progress better.

Amanda Campbell: If I could just add, the new service model that Julie has described, we are measuring our performance against those aspects of the service model and then using the information that comes out of that to challenge and test. The new internal audit report that has taken place this year, in this financial year, so outside of the terms of this report, has been specifically about our case work processes and the assurance around those case work processes. That has come out saying that there is significant assurance of those processes now.



I am looking, with my executive team, at how each team across the business is performing against the different aspects of the service model and they are rated on a red, amber, green. We are able to determine whether there are things that just simply need to be changed or whether there are real problems. So when we have identified, for example, a discrepancy between our assessment of whether we are doing something well, so the process is being done, to a difference with the customer satisfaction scores where the customer is saying, "That doesn't feel very good for me" but we think we are doing something right. We are looking at where there are discrepancies and saying why is that and what are we getting wrong. Perhaps we are measuring the wrong thing.

Sharing emerging findings is a good example of this, where our new service model has fundamentally changed the interactions that we have with people. Previously our business was very paper based so a complainant would come to the organisation, we would look at all of the papers, call for lots of papers, correspond with people but not speak to people very often. At the end of that, over often a quite lengthy period, we would write back to them with a very detailed report. The new service model now means that there is engagement with complainants at every stage, including at the beginning where we scope the investigation so we understand really what the individual who is complaining wants in terms of the resolution, right the way through to at different points in the investigation calling and making sure that we are keeping people up to date. One aspect is sharing emerging findings. It was something that was referred to in the evidence from PHSO the facts, where there was a lack of transparency about what organisations were telling us and we would simply synthesise and write in our report. We now have a stage in our service model which is to share the emerging findings. So when the organisation comes back to us with their explanation, we make contact with the complainant and we say, "This is what the organisation has told us, this is their response" we have a discussion about that and therefore share much more information than we previously did.

What was clear from our customer satisfaction scores is that we were still not getting that experience right. So we have gone back out with some training for our investigators so that we can understand from them the things that they find difficult about that process and talk to them about how we can improve that. Again, the most recent scores are starting to see a shift in that. So it is a learning model whereby we look at the evidence, we review it, we look at discrepancies and then we do something about it.

Q40 Dr Dan Poulter: Thank you, that was very helpful. I just have one final question; it is more of a clarification than anything else. It sounded to me, Dame Julie, from your earlier answer as if you were saying there is no issue with the data that the board received. I just wanted to reconcile that with what the internal audit report said because on page 16 of the report it did highlight the issue of inconsistent presentations to the board. I just wanted to understand why you are now saying that was not the



case.

Dame Julie Mellor: I think I may have to come back to you because my understanding very clearly when we looked at it was that the information to the board was at a higher level and therefore the concerns expressed in the audit were not, in the end, about the information that went to the board but I am happy to come back to you.

Dr Dan Poulter: That would be helpful just to clarify that point. I think also perhaps have a little bit more detail—through you, Chair—about some of the useful information that Amanda Campbell has just given about prospective working forward as well.

Q41 **Ronnie Cowan:** This Committee receives a steady flow of complaints from members of the public who are dissatisfied with the PHSO, groups like PHSO the facts and the Patients Association have publicly criticised the PHSO, so how does the PHSO respond to this widespread concern?

Dame Julie Mellor: I am obviously reflecting on what we heard from the other evidence session and I would say we absolutely share the desire to improve our service. There are lots of things that we agree on. When I first spoke with PHSO the facts their most significant concern was about the number of investigations that we did, that we did not do very many. That is where we started and, as you have heard already, we are now doing roughly 10 times more investigations and getting five times more people having things put right for them as a result so that is one area where we engage with them and we have improved something.

Coming back I think the service charter and that focus on developing that with PHSO the facts, with the Patients Association, with the various advocacy bodies that have contracts to provide advice locally we have developed this charter.

One of the big challenges you heard in that evidence session, and I heard, is the challenge of managing expectations and being clear on the purpose of an ombudsman service. When people approach an ombudsman service, they have been through an unsatisfying procedure and are filled with emotion. Then they can find that we can only look into their case if they have been through the complaints process of the organisation concerned and they would hope that what they believed has happened would be upheld by us and it can be upsetting when we investigate impartially and determine something different to what they expected.

I recognise some of those challenges and that is why we have both produced the charter and done a huge amount to provide clear, straightforward information about our service to help manage peoples' expectations from the beginning. If you have not looked on our website I would strongly recommend it because there is very good, straightforward information about step 1, step 2, step 3, what happens, what we can and cannot decide, how many people, how long it takes, and so on.



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Q42 **Ronnie Cowan:** At the end of this five-year strategic plan are we going to recognise the PHSO as it is now or is it going to look like a completely different organisation?

Dame Julie Mellor: I would say two things. We are already a different organisation in terms of the numbers of cases we are looking into for people and are already a different organisation in using the insight from those higher volume of cases to work with public services to help them improve and indeed to bring the insight to this Committee so you can hold Government to account for learning from mistakes.

We are nearer the beginning of the journey on the service and the service charter we launched in July, having spent some time working it through with people, is the start of that. The first look at how we are performing on that will be available in the New Year and yes, I would hope by the end of the five-year period there would be improvements in service there. We have already seen improvements in terms of timeliness. As Amanda was saying we have seen an uptick in people feeling kept informed from 50% to nearly 75% now feel they are kept informed during the process. There are already improvements but we are part way through and I would expect to see more by the end of the five years.

Q43 **Ronnie Cowan:** It has been said that the needs and expectations have moved on but the Ombudsman has not. So, there is a different view coming from inside the ombudsman service than there seems to be from outside.

Dame Julie Mellor: I think the influence of Ombudsman watchers that every ombudsman service will have is a challenging issue both for us as a service and for our democratic sponsors because we obviously have the desire to draw lessons from the experience of people who are not satisfied. But we also and you also have to recognise the risk of privileging potentially unrepresentative views, which again is why what we are doing with our service charter is so important because we are triangulating the evidence and making sure we have customer feedback more broadly just than particular critics as well as process assessment and checking of decisions. I think that is the right way to look in the round at how the service is doing.

Q44 **Chair:** Can I pick you up. You used this term, that we might be "privileging" a certain set of views. Can you tell us what you mean by that?

Dame Julie Mellor: As I said, we all want to learn from people who are dissatisfied with the service and that is why we have involved people. But they are not going to be the only people and there is a wider set of evidence about the quality of the service through the quality assessments we make and the feedback we get from our customers.

One of the things staff asked me to say today is how they see every day cases written up in local newspapers where people have been very pleased with the outcome and sometimes even where the case is not



upheld we get letters from people saying how thorough we have been and while it was not the answer they expected they are pleased it has been looked into thoroughly and that they accept the findings. All I am saying is we all need to make sure we look at evidence in the round.

- Q45 **Chair:** You heard if anything that this Committee is subject to criticism for failing to transmit sufficiently clearly to you about dissatisfaction with the service. How do you think we can better understand this issue about the quality of your investigations because either we take it from you or we take it from somebody else? Who should we take it from? How do we get a balanced view of the quality of your investigations? It seems to be the most difficult thing for us to do.

Dame Julie Mellor: I have a couple of thoughts. One is in terms of our accountability. We recommended and you have supported the idea that the future accountability arrangements for the future public ombudsman service are strengthened by separating the role that PACAC will continue to have in using our insights to hold services to account for learning from mistakes and separating that from the scrutiny of our service as a parliamentary institution. I think that will make things simpler and clearer for two different Committees of the House to fulfil those separate roles.

The second point is, as I have already said, I think that scrutiny should formally include the quality of the service overall and I am probably beginning to sound like a broken record but I do think the innovation of our service charter will over time give you in a really clear way the kind of information that will enable you to assess that quality.

- Q46 **Chair:** In particular there are two things I would like to pick up about the quality of investigation. We heard from one of our earlier witnesses that basically there seems to be a subjective approach to the application of guidelines to the assessment of an investigation. What is your response to that?

Dame Julie Mellor: This is something that has been tested in law, not in my time but previously. As I think Della Reynolds was explaining, when we look at a complaint we look at what happened, what should have happened and is the gap wide enough that we would uphold or not because we think what happened was unreasonable. We have to look at a whole range of things in the round. If people are saying there is a straightforward contravention of the law then they would have to go to court. We will look at the legal issues, the policy issues, the standards and guidance in the round to make an assessment of whether something is reasonable or not and that is a judgment.

- Q47 **Chair:** It is one thing to ask you to adjudicate on the law as a matter of law. Obviously you are not in a position to do that but surely you take into account whether you think the law has been broken regardless of whether there is going to be a prosecution or a case in law. Surely that is a relevant matter.



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Dame Julie Mellor: We do not formally interpret the law but we will look at that as part of the standard. The example that went to judicial review was Mencap traditionally reviewed our approach to allegations of avoidable death for people with learning disabilities. This is prior to my time. The court upheld the approach we had taken in that where there might have been a technical breach of the Disability Discrimination Act we would consider that in the round with everything else that happened rather than automatically upholding because of a technical breach of the legislation and that was supported by the courts.

Q48 **Chair:** Another criticism we heard is that there is a feeling that the safe space that the Ombudsman has access to for investigations is somehow abused and not trusted. That is understandable if people are unhappy with the investigations but how do you respond to that particular?

Dame Julie Mellor: You made the case yourself, Chair, in saying the reason for the safe space is to make sure people feel comfortable giving evidence.

Q49 **Chair:** Given you have that safe space why can you not include complainants in that safe space so they understand what is going on? This is what would happen in, for example, the Air Accident Investigation Branch of the Department for Transport.

Dame Julie Mellor: As Amanda was saying earlier, this is exactly where under our service model we have changed our practice and we do share facts earlier. We do share our thinking about where we think it is going and we ask people not to share the information until there is a final report because of the safe-space issues. But we do share the information with people now.

Chair: I am terribly sorry but we will have to suspend the Committee for a few minutes for a personal reason. I wonder if we could clear the public gallery as well, please.

Sitting suspended.

On resuming—

Kelvin Hopkins took the Chair.

Q50 **Kelvin Hopkins:** We can resume again now and apologies for the interruption. The Chair had to be called away. As it happens it was my question next and it really follows on from what Dame Julie and Amanda Campbell was saying about the service charter.

It is obviously easier for large organisations like the ombudsman service to source well-structured evidence than it is for complainants and I know Amanda Campbell had talked about having conversations with complainants as well but many individuals complained to this Committee that the ability of a large organisation to present evidence biases the PHSO investigations towards the institution it investigates. Naturally a hospital trust can provide very professional evidence that is somewhat unequal to what a complainant might put. How do you ensure that



investigations do not incur such bias?

Amanda Campbell: Starting is the conversation we need to have upfront with the complainant and to make sure that we fully understand what they are complaining about and that when we scope out the complaint we have covered all the aspects that are really important to them. We heard earlier on the evidence session that sometimes in the past we have not done that well enough so the new model and new way of working is very much to do that.

We are at the moment just installing a new casework computer system in the organisation that will bring a whole range of efficiencies for us. One thing it does is go through a very structured way of scoping a complaint to make sure we record in some detail exactly what the complainant wants us to investigate, that we have discussed that with them and agreed at the beginning what that is. I think that will help because there have been, as I say, some of those misunderstandings.

We then need to make sure we call evidence and involve the complainant as we go through this as we have discussed but it is important to remember too that we are not an advocacy organisation. We are there to determine impartially the facts of the case so therefore in calling evidence from the organisation we look at that in the same impartial way and listen to the individual and their views.

However, the emerging findings stage is a really important one now because it gives us the opportunity to talk to the complainant about what we are finding, about what the organisation has said and that was not there before. The first the individual got to hear about our findings was when the report landed on their doorstep and that is a very different picture now than it was before.

Q51 **Kelvin Hopkins:** We heard from Dame Julie that obviously there are some satisfied complainants who say thank you but clearly there have been many who have not felt like that. Do you expect your new approach to complainants and dealing with them in a more personal way will reduce this level of complaints and do you have evidence so far yet that accusations of bias are less than they were?

Amanda Campbell: The areas where we have the most satisfaction are first of all about the delays in waiting for a complaint to be investigated and also the fact that people were not being kept updated about what was happening. There is also something about our final reports and how complicated they are often for people to understand. Those are all areas we are working on.

As we mentioned earlier our timeliness is getting better. We started this financial year with a big waiting queue at intake and also at assessment and investigation and we have been working through those backlogs, clearing the queue at intake and that is now down to just daily frictional levels. Clearing the queue at assessment is down to the same position.



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We still have a queue in investigation. Some are working very hard to try to bring that down but people in that queue are waiting for much less time because we are working through the older cases to try to resolve things more quickly. So, on timeliness that is an area where we are making progress. We are not at the end yet but there is definitely a change.

The updating individual complainants about their cases again, as Dame Julie mentioned, the new customer satisfaction checks we are doing on our service charter has shown a 25% increase, just under 25%, in terms of people being satisfied they are being kept updated so that is really important and positive. We are also looking now as an organisation at our reports. They are very high quality, very lengthy and very detailed. We need to make sure they meet the requirements of the individual and we explain things in the most straightforward way that everybody can understand, so that is another stage we are working on.

Dame Julie Mellor: If I can just add a couple of things, I do think this is a crucial issue that has a number of factors feeding into it. We have found some things that are making a difference like sharing facts and explaining our thinking early on. There is much more we can do in the way we write our reports and that is part of our continuous improvement plans.

I also think this issue of expectations comes in here because this is where explaining up front what we can and cannot do is really important so that people are not disappointed at the end. They understand at the beginning what is possible and I think that managing expectations in and of itself could also reduce perceptions of bias over time.

Amanda Campbell: One of the things I think is going to help that particular issue is we have been developing a new website and we have been doing that with the help and support of a range of organisations that have been contributing to the design of the website. The website will be launched early in the New Year and one of the aspects of the new website is a complaints checker so you can go on the website and put in the details and it will say to you whether your complaint is at a stage that can come to us or if there is a more appropriate way to deal with the complaint at the stage it is on. Hopefully that will help people give more information about making sure they access us at the right time.

Kelvin Hopkins: Thank you. That is all very helpful. I just wondered if we can perhaps try to make our answers reasonably short because we have quite a number of questions to go through as yet.

Q52 **Ronnie Cowan:** Continuing this theme of managing expectations, it is clear from much of our correspondence that many people are unaware of the PHSO has a process of reviewing decisions it makes. So, when you are notifying somebody of the outcome of their case how do you notify them that can be reviewed?



Dame Julie Mellor: We have changed it. We used to say to people in the letter if you are not happy with this decision you can ask for us to check the process and therefore whether the decision is reasonable. But because of this issue of helping people understand the decisions we changed it and we said if you have any questions or feedback please contact our customer care team. We have found, as I said, the customer care team are able in many instances to explain the decision in a way the complainant is then satisfied with the outcome.

Q53 **Ronnie Cowan:** What if they are not satisfied with the outcome?

Dame Julie Mellor: Then for quite a long time now and partly out of a dialogue with a previous member of this Committee, Greg Mulholland, if someone feels that the decision is flawed or there are new facts that none of us were aware of when the investigation took place or factual inaccuracies then we will ask a reviewer to review the process of the case to see if what we did was following a proper process. If there are new facts or the process was flawed then we re-open investigations or sometime it would be a fresh investigation.

Q54 **Ronnie Cowan:** Who would run the fresh investigation? Is it still within the PHSO?

Dame Julie Mellor: Yes.

Q55 **Ronnie Cowan:** So, the PHSO in effect is investigating their first investigation.

Dame Julie Mellor: I think humans are fallible and make mistakes. That is what we say when we uphold cases. We are no different from that, which is why we have this process of people being able to review it. But once you know what the issues were then you can make sure they are dealt with when you are re-opening the investigation or launching a fresh investigation.

Just to give you a sense of scale, two years ago we had 392 requests for reviews and we re-opened or launched fresh investigations in 78 of them. Last year, partly as a result of people getting better explanations, fewer people asked us for review, it was 217, and in 14 cases we have re-opened or launched a fresh investigation. That gives you a sense of the scale and those 14 think it is perfectly proper for it to be done within the organisation.

Q56 **Ronnie Cowan:** Can I ask the previous speaker, you were talking about a new website.

Amanda Campbell: Yes.

Q57 **Ronnie Cowan:** Has it been designed with accessibility in mind?

Amanda Campbell: It has indeed and a number of organisations have been working with us to make sure it as accessible as possible.

Ronnie Cowan: I look forward to seeing it.



Q58 Kelvin Hopkins: I have a quick additional question here. Some complainants say they are referred to the customer care team but do not really want to go through the customer care team. How do you measure satisfaction with your customer care team? Are you happy with them?

Dame Julie Mellor: As I said they have just won an award for the best customer contact centre so that is an external recognition of the great service they are providing. I sit on the phones with members of the customer care team sometimes and I think they are providing a great service of listening, understanding what someone is concerned about and either providing an explanation or saying, "Yes that sounds like there may be an issue. Let us put that forward for review."

Kelvin Hopkins: Perhaps we can pursue that another time.

Q59 Mr Andrew Turner: I am rather concerned that lots of things have changed and are changing and still will become changes. I am not at all clear which things are already implemented, which things are going to be implemented, which things were implemented a year ago or five years ago. Could you give us a written list of the key changes that have happened to your organisation for the last two years and going on for as many years as there are?

Dame Julie Mellor: We could. I explained at the beginning that we are on a five-year journey because we know that change takes time. We have made some fundamental changes and certainly on service quality it is more about continuous improvement now so it will depend upon the feedback we get back what we then focus on to improve. I think you can say we have changed the numbers, we have changed the impact through more thematic reports, we have regularised our governance, we have sorted our financial processes and we are now at more of a stage of continual improvement on the quality of the service.

Q60 Mr Andrew Turner: Good. If you were able to put those in writing that would be very helpful to me at least and I think that would help me or help you by not requiring detailed responses to my next question. Complainants feel that the PHSO has not adequately understood or addressed the subject of their complaints. What processes, I ask, do you have in place to make sure the scope of your investigation matches the complaint you receive? It seems to me that is something that you could say, "I'm going to respond to this in a meeting" to or you could go on and explain to people.

Amanda Campbell: I think that was part of what I was mentioning just now, particularly about our new casework system, IT system, that helps us structure scoping in the complaint in a much more straightforward way. It is certainly an aspect that we have been working very hard on to resolve, because it is an area where we know in the past, and we have heard from the earlier witnesses that that has not necessarily always been right. I would be very happy to explain that to you in more detail about how we are doing that.



Q61 **Mr Andrew Turner:** Thank you. You reported that only half of your stakeholders feel that the PHSO is good at providing recommendations. When does this half of stakeholders apply? Was that two years ago, one year ago, five minutes ago?

Dame Julie Mellor: I am not sure of which piece; was this in our memorandum to you?

Mr Andrew Turner: I think so, yes.

Dame Julie Mellor: It was probably—I honestly don't know if it was last year or this year.

Mr Andrew Turner: Okay. Thank you.

Q62 **Dr Dan Poulter:** One of your strategic aims for this year and for next year is, "Improving how we use insights from individual cases, and systemic investigations to bring about change". However, I believe that your stakeholder survey results show that only 31% of your stakeholders feel that you perform well in sharing insight from your casework. What efforts have you made this year to communicate insight from your reports to stakeholders and how are you setting that on an ongoing basis?

Dame Julie Mellor: That is probably fair feedback in that it goes back to the point about being on a journey. Where we have had very significant success is in the reports we have done that have then been picked up by this Committee, and so we have seen some real concrete action taken as a result, for example, of our joint work on sepsis or midwifery regulation, which we discussed when you had another hat on, Mr Poulter. The success that we are achieving jointly on raising the issue of the poor quality of incident investigations is demonstrated again today with the CQC report that Bernard Jenkin was referring to earlier, so I think we have made huge progress.

There is a lot more that we can do on a more day to day basis and the casework management system, which Amanda was referring to, will enable us to much more easily pull out the insight in terms of the themes that are coming out of investigations and share that with the bodies themselves.

Q63 **Dr Dan Poulter:** Just on that, something that occurred to me is that obviously you have a different function from a regulator and you mentioned one of the regulators just a moment ago, but are there any lessons that you can learn or pick up from how the regulators have looked at these sorts of issues in the past and are there any areas of learning, in terms of how they have looked about gaining that insight from individual cases to improve how they handle the complaints that are brought before them?

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



Q64 Dr Dan Poulter: Some of the healthcare regulators have gone through—the NMC, for example, in the past—some very difficult times and have recognised that some of their processes were, in terms of speed of case handling and in terms of timeliness of case handling, at fault and they have addressed some of their internal systems and become more responsive, and I wonder have you had any conversations with those regulators to help you in addressing some of those issues yourself?

Dame Julie Mellor: We share learning regularly, both ways. I do think our major intervention has been the creation of the service charter, which are commitments that the public have said they want us to make and that will help them feel confident in our decisions. It is continuous improvement against that that is probably going to deliver the most change for us but, yes, we obviously work with regulators.

We have to be careful about being clear about the different purpose of the organisations. I was thinking about what Scott Morrish was saying about a need for a greater focus on learning, and actually because so many people who come to us want their complaint to make a difference, they complain out of a sense of duty that they don't want what happened to them to happen to someone else. It is very often part of the remedy that we will say to the organisation, "You have to go and look at why this happened and look at what action you are going to take to improve as a result of that learning". But our primary purpose is to put things right for individuals, which is very different from the primary purpose of a regulator.

Q65 Dr Dan Poulter: Indeed. Last year in your evidence session to the Committee, I understand you explained that your internal affairs team is responsible for sharing what you learn from complaints with others to help you make public services better. I think some of that is a direct quote. How much do you measure the progress your external affairs team is making in this area?

Dame Julie Mellor: We measure progress annually through: have we achieved what we said we would achieve in our business plan, and is it having the impact we expected? Then we measure progress against our five-year strategic plan of: is our strategy having the impact that we hoped? Those metrics are recorded in our annual report and in our memorandum of understanding.

One of the biggest benefits of the way that we are now doing more cases and have more insight is the insight that we are able to provide to you, and so I would regard it as a mark of our success of our insight team that we are producing regular reports that you want to use to hold Government to account for learning from mistakes.

Q66 Dr Dan Poulter: The external affairs team budget makes up, I think, around 9% of your total staff budget, which by my off-the-top-of-my-head calculations are about £2 million a year on external affairs. It has gone up by £300,000 this year. How do you assess the value for money



of spending a high proportion of your staff budget on external affairs?

Dame Julie Mellor: You have asked us about this before but you were not on the Committee, and I would give the same answer, which is: our external affairs' function is about insight and communications, and the insight we have just been talking about. Part of the value for money is how many people are impacted by our insight report. In the case of sepsis, if it works it will be many thousands of people a year. On the communications side, then I think some of that we can measure through the results—I really am feeling like the broken record—in relation to our service charter, because one of the four chunks on the service charter is about people understanding our role and having information about what we do. The communications function has been responsible for all of that work and what is available on the website that is helping people understand what we do.

They also do the case summaries that we put online. Our staff who complete the cases will write a short summary. Those are then edited and made suitable for external presentation by that communications team. That is something that, certainly when I visit NHS providers, they report that they find incredibly useful because they can look up the kind of issue that they have had a complaint about and look at what we have adjudicated in a similar case. MPs can also use it, so the measures are about the use of that information by the public and all of that is in our KPIs that are in the annual report.

Q67 **Dr Dan Poulter:** Given that there were some financial concerns raised with the organisation: issues of coming within budget. There were some issues about—

Dame Julie Mellor: Sorry, I am just trying to hear.

Dr Dan Poulter: Given there were some issues about the financial concerns raised about coming within budget, I wondered how effective in that you believe spending, I suppose, 9% or £2 million on external affairs and, in view of those financial concerns, increasing that budget by £300,000 is effectively financially responsible?

Dame Julie Mellor: So, two things: obviously as part of our Comprehensive Spending Review settlement then all of our functions are looking at how they can remain as fit for purpose as possible and achieve our savings. The other thing is about value for money more generally. We got the support of our auditors last year to look at value for money across the organisation and what we should be looking at. What we have to remember, when we are looking at value for money, is we are looking at economy: are we getting the best value for the inputs? Efficiency: are we getting the outputs for the input? Effectiveness, which is around impact, and equity, are the benefits distributed across?

Ultimately, what the NAO has said to us is it is the achievement of our strategy that demonstrates value for money. I think in relation to our external affairs function, then that value for money issue on



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effectiveness, the impact we have, is very, very evident from the insight we have drawn out from complaints and the much better information that we are providing for the public.

Q68 Dr Dan Poulter: You investigated fewer cases in 2015-16 than you did in 2014-15. Why would that be the case?

Dame Julie Mellor: We dealt with that one earlier. Mr Jenkin asked a similar question.

Dr Dan Poulter: He did, but it would just be useful to go over that again, just briefly, before I elaborate on my line of questioning.

Dame Julie Mellor: Okay. The numbers will vary year on year. We are finding that of the 29,000 people who come to us 75% of them we are able to give them information on how to complain and how to get a final response from the service provider. For the 25% that are ready for us, in that it is a body that we can look at, an organisation we can look at, and they have had a final response from that organisation. Then we find that there is some indication of a potential problem in about half of those. It does seem, year-on-year, it is around the 4,000 mark, but it will depend upon the particular cases that come in how many we actually take on each year.

Q69 Dr Dan Poulter: There is some variability year-on-year as you say. That is understandable. Given the previous answers that you have given—and we talked a bit about the budget—do you feel it appropriate within quite a difficult spending environment to prioritise, to increase the amount of money being spent on the comms budget, the PR budget, to the expense of the money spent on investigations?

Dame Julie Mellor: Sorry?

Dr Dan Poulter: Do you feel that potentially it is a good decision to make to increase the relative amount of money spent on the comms budget by £300,000, in financially tight circumstances, rather than increase or put that money directly into investigations?

Dame Julie Mellor: It depends what you are trying to achieve. I am very clear that what I have wanted this organisation to achieve is to have more impact for more people. The way that we have done that is by both investigating more cases but also then using the insight to have a greater impact. All the complainants I met when I first started said, "I want my complaint to make a difference". All the feedback we get when we produce the insight reports from the individual complainants is, "This is what I wanted". The learning from mistakes report that was about the Morrish family's experience is an example of that. So I would say, yes, it is absolutely, in terms of what the public want from this service, it is really important that we can do the insight and we can work with you on what comes out of that work.



Amanda Campbell: It might be worth adding—I mentioned the development of the new website—some of the additional funding was in relation to developing the new website. By doing that in the right way we will enable people to go to the right organisation rather than to come through our doors, so if we can make sure that the people that come to us come when they are ready that makes our system much more efficient. The investment at the frontend, of making sure that we give people the right information at the right time, helps the efficiency of the whole system.

Q70 **Dr Dan Poulter:** Do you think there is an argument within the confines of the budget that you have that, when there is an investigatory—the public see the importance of engagement and investigation as being a core function and that investing more in that may offset some of the criticism of the service that we have heard earlier today, in terms of how some of the cases are handled? It might be your decision to put more money into communications rather than investigation that could increase the time it takes to deal with certain cases because there isn't the money and the resource to do that. Is that a valid criticism would you say?

Dame Julie Mellor: The issues of meeting demand and timeliness are different. We are finding a greater number of cases that we should take on because there are signs of something potentially having gone wrong that caused injustice that hasn't been put right. The issue of timeliness has been much more one of catching up with the changes that we have made, so it is not an issue of not being able to meet demand at the moment; the timeliness is about underestimating the resource that was required when we moved to doing many more investigations.

Amanda Campbell: As a general point, in looking at our budget reductions over the next three years, I am certainly looking at how we can protect as much of the essential frontline activity as possible, so, therefore, looking at where we can make a savings in terms of our accommodation; in terms of the other support to our business, as opposed to the key people in our business, who are conducting the investigations, or, as Julie has already described, preparing the insight so that we can share that across the organisation, but very conscious that we want to protect as much of the frontline delivery as possible over the next three years.

Q71 **Dan Poulter:** Okay, and just last question for now, so thank you. In your supplementary evidence to this Committee, you reported on a further decline in your performance against your service standards overall for 2015-16 since last year. Why was this not reported in your annual report for 2015-16 as it was in 2014-15?

Dame Julie Mellor: Okay, that is absolutely my responsibility, and I explained it to the Committee last year. We still use the same standards as targets for our operational management, and that is why we have been able to provide you with the information when the clerks requested it. However, I am very clear that, knowing whether 65% of cases are



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completed within 13 weeks is not meaningful for a member of the public, and so our standards for the public are expressed in a way that is meaningful for them.

We say on our website that step 1, which is where we look at whether we can investigate, we aim to complete within five days. Step 2, which is where we consider, should we investigate, is there any indication of a problem, we aim to complete in 20 days, and, for investigations, with our new service model, we will explain to the person using the service, the complainant, how long we think an investigation will take in their particular case so that they have an idea in relation to their particular case, and so that is why, in terms of service standards, those are the service standards, and that is the information we put on our website for customers so they know what to expect. That is different from our operational management of the throughput we would expect if we were meeting demand.

Q72 Dan Poulter: Following that, your annual report does mention the average investigation took 263 days or 8.6 months in 2015-16; your target is to complete 95% of investigations within six months. Why do you feel you have not been able to meet this target?

Dame Julie Mellor: They are the operational throughput we would expect, rather than a service standard for the public, so I think we are conflating things now. What is your concern?

Q73 Dan Poulter: Why have you not met your target?

Dame Julie Mellor: Sorry?

Dan Poulter: Why have you not met your target?

Dame Julie Mellor: At the end of last year, the total time taken end-to-end was 263 days on average. So far, this year, it is 234 days. In 2012-13, it was 392 days, so you can see the trajectory of the reduction in time that we are taking.

Q74 Dan Poulter: Yes, and which is a positive step, but, taking the example from health care regulators, for example, a number of the health regulators have faced similar concerns over the time they have taken to investigate cases, but have, I think, acted relatively rapidly to address them. One of the concerns we heard earlier from some of the earlier examples was concern over the time to deal with cases. Do you feel you are getting on top of this issue quickly enough?

Dame Julie Mellor: Sorry, we are getting—

Q75 Dan Poulter: Do you feel you are getting on top of this issue quickly enough?

Dame Julie Mellor: As Amanda has already said, our timeliness is something that we are focused on, in order to meet those service standards that we have expressed for the public. We underestimated,



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when we first introduced more investigations for more people—we underestimated the number of people we would need. We started 2015-16, I think, with just over 2,000 cases waiting to be allocated. We said to the Committee that we expected all of those people to be served by the end of 2015-16, and they have been.

However, in the meantime, with planning for our budget reduction of 24%, that included a recruitment freeze, and we have built up some more people who are waiting to be served. We have eliminated people waiting for the step 2 where we decide if we should investigate, and we have seen a very positive movement from people waiting on average 63 days for an investigation to start last year to it is now down to 28. We are not where we want to be, but the direction of travel is in the right direction.

Amanda Campbell: One of the areas that we are improving at the moment trying to resolve more complaints more quickly, so looking at where we can do so in a more informal way, rather than going into quite a lengthy formal investigation, and you heard in the earlier evidence session about a request to do much more of that, and that is certainly a direction of travel.

If we can resolve a complaint that comes to us by having a conversation with the organisation and with the complainant, and getting the remedy that is sought without the need to go through a detailed and lengthy investigation, that is obviously better for everybody concerned, and particularly for the complainant, because they get much earlier justice, so those sorts of initiatives will have an impact on the overall waiting time, because we will be better at triaging, so that those that we can resolve more quickly we will, which leaves us more resource for our more detailed and complex investigations that are going to take more time, often multi-jurisdictional investigations, and we will have more resource to dedicate to those, because we have taken easier-to-resolve complaints out of the system earlier.

Q76 **Dan Poulter:** Finally, and then I will hand over to the Chair. On resource: more money can buy more resource. Picking up slightly upon one of the questions I asked earlier, you commented, I think, that impact is the key thing for you in terms of your communications strategy, increasing impact, public impact, and the amount you spend on communications, makes sense, because you feel there has been an increased impact.

What do you mean by impact? Is that the same as publicity? As only 31% of stakeholders feel that you are good at sharing insights to improve public services—that is from your annual report—do you feel that you are making the impact that justifies that £300,000 increased expense this year?

Dame Julie Mellor: Impact is not the only thing. The insight part of the Insight and Communications Division deals with the impact for a larger



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number of people. As we have said, the communication side also deals with making our service accessible. It is responsible for the website. It is responsible for how we communicate, so that is making our service more accessible, which is another aim of ours.

Let me have a look. If you look on roughly pages 40 to 44 in our annual report, it takes you through the range of measures that we use, and so, in terms of the first one, the communication, then issues around whether people have heard of the ombudsman service, whether they feel satisfied with the service, and understand our role, are some of the measures that are there, and then the ones about impact are later on. There are concrete measures that are in our annual report that help us ascertain whether we are getting value for money in the long term for all of our work.

Q77 Kelvin Hopkins: Thank you very much. A question on the strategic plan now. Your organisation is now halfway through its five-year change plan. How have you assessed progress against the plan?

Dame Julie Mellor: I think that is in the end of some of what Mr Poulter was asking. In terms of giving a general assessment of progress against plan, then I think we have made good progress on opening our doors, getting justice for five times more people, halving the time it takes us further to go, as we have been talking about in terms of the timeliness, that we are on the right path; good progress in terms of being a much more transparent organisation, working with critics and users of our service to make sure that we learn from where people are not satisfied, and have a completely different way of measuring quality as a result; good progress on our work with you. The midwifery regulation, we hope, is imminent, as a result of issues that we brought to your attention, and you held a hearing on.

I do think there is something longer term that this ombudsman service and this Committee will need to think about, which is we are seeing action taken, but whether it has the desired impact, it will take a lot longer to know, and so I think something that we need to consider together is how does Parliament come back to look several years down the line.

The UK Sepsis Trust said 12,500 people might have their lives saved if the actions that we recommended, which are now being taken, were followed through, so I think Parliament could come back to that at some stage, and how that is done, I think, is something that would be worth talking about.

In terms of assessing progress overall, we have also regularised our governance within the existing legal framework, and it now reflects best practice.

The area that we have made less progress on is developing the organisation. Hence, your questions about our finance and so on, so



developing the systems and processes and controls for the new service that we provide, and new ways of working, for dealing with rising demand, for the 24% budget reductions, and that is why there is so much focus on the work that Amanda and the team are now doing on those areas, so that the development—and staff engagement is part of that—so that those elements of what we want to achieve are now being prioritised.

Q78 Kelvin Hopkins: Thank you. In July this year, we know you announced your resignation, and there is obviously the issue of continuity. Do you think that continuity of the change plan will work? You have Amanda Campbell now, your new Chief Executive; do you think there will be problem with continuity?

Dame Julie Mellor: I think we are a lot better equipped to deal with change at the top now than when I arrived. Because we have a unitary board and that proper separation of executive and non-executive functions, when someone replaces me, they will have a board there and an executive team, and a strategy in place. They will obviously want to review the strategy for themselves, but, when I took over, because it was very much operating as an individual, then it felt like there was no continuity, whereas now you have a board for someone to chair, and a solid executive team who are moving the organisation forward, I think the continuity should be a lot easier.

Q79 Kelvin Hopkins: I should say do not hold back from answering answers twice, more than once, if it is appropriate, particularly if you answered it at a previous meeting, because it may set context and be helpful.

Awareness of the Ombudsman has fallen by the 7% this year, and your 2016-17 business plan says that you do not plan to invest in any further awareness-raising efforts. In light of this, how realistic is it to state, in your annual report, that one of your strategic aims for 2015 to 2017 is, "Raising awareness of our services, and making them more accessible"?

Dame Julie Mellor: A five-year strategic plan sets out what you wanted to achieve on day one, and you obviously need to regularly—we review annually—how we are doing against our strategic plan, and what we can do in the future, and it is a source of disappointment to me that we have not been able to focus on raising awareness, because I think there is unmet need out there, but this is about pace, and so we needed to make sure that we could meet demand before we could consider raising awareness. As I said in a response to a query from the Committee on our estimates, I think a 24% spending-review reduction will question whether that aim can be taken forward, even when we are meeting demand, because, actually, we are seeing increasing demand, as well as the spending cuts, so it may well be in refreshing the strategy that that disappears as an aim in future. That will be something for the board and my successor to consider.

Q80 Kelvin Hopkins: There is obviously an equation between external



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awareness of the Ombudsman and demand; the more people know about it the more demand there is likely to be. In your annual report, you state that you are now "meeting demand". What assessment have you made to satisfy yourself that everyone who needs your service is aware of it and that you are, indeed, meeting demand?

Dame Julie Mellor: To be accurate, the demand we are meeting is the demand that presents itself to us. I think we have rehearsed the argument about why we have not generated demand. I am disappointed awareness has not gone up. As our staff said when I was asking them what they wanted us to say today, they were saying that they feel there is a lot more out there about us now in local newspapers, which will help people know. We are seeing more people coming to us, so I am surprised that is not reflected in awareness, but I am pleased that people are coming to us if they feel they need to.

Amanda Campbell: It might also just be worth noting that the surveys show that there is a real difference between if you ask people if they are aware of the parliamentary and health service ombudsman than if you just simply say, "Are you aware of the health service ombudsman?" There is a percentage differential that is quite significant; 10% more are aware of the health service ombudsman than if you say the name of the organisation in its entirety. We need to understand why that is and as we go into the public debate about the public service ombudsman, it does give us an opportunity to talk more publicly about the roles that the respective organisations do.

Q81 **Kelvin Hopkins:** I understand that awareness of the Ombudsman is at its lowest point since 2012-13, which is obviously a significant period. Presumably, that is asking the same question. You say changing the question would give a different response, I understand that, but with the same question we still see it is at its lowest point. Isn't there a job to do in making people more aware?

Dame Julie Mellor: As I said, yes, of course, there is and it is frustrating that we have not felt able to, but we needed to be responsible. We needed to know that we could manage the demand that was coming to us on a timely basis before we then invested in further effort to raise awareness.

Amanda Campbell: This year also, as we mentioned earlier in the hearing, we are seeing demand rise and I think that is an indication perhaps of greater awareness. The number of people calling the organisation is rising and the numbers of people that we are taking through into the assessment stage is rising. If we continue on the numbers that I am currently seeing, it is likely that we will have the highest ever number of cases at the assessment stage over the course of this current financial year. I think that is part of the awareness raising that we have talked about; the press reports of the sorts of injustices that we have remedied that are often quoted in local newspapers.



Q82 Kelvin Hopkins: Just pursuing this a little further, you previously wrote to this Committee to explain that your external affairs team is responsible for making it, “easier for people to find and use our service”. The external affairs budget rose this year, despite it no longer being a retention, to further raise awareness of the Ombudsman in 2016-17. Why is this, do we know?

Dame Julie Mellor: Within our first aim in our strategic plan there are different elements to it and one is about raising awareness. I think we have explained that there is increasing demand but we have chosen not to spend money and effort on raising awareness until we are more comfortable about timeliness of meeting demand.

The other part of it is about the accessibility, and I think that has come up earlier in the hearing. Part of that strategic aim is about making sure that it is easy for people when they contact us to understand what we do and what they need to do. We have talked earlier in this hearing about a range of activity, the website, the guidance for complainants, and people having a clearer sense of what we do as a result of that information. That is another part of that aim.

Kelvin Hopkins: Thank you. I could develop that but we will move on to Mr Cowan.

Q83 Ronnie Cowan: You mentioned a few moments ago you were looking at 24% cuts. When can we expect a savings plan to be published?

Amanda Campbell: We have made a proposal obviously to the Treasury under the Comprehensive Spending Review that sets out how we propose to reduce the amount of budget that we have over the course of the next few years. We made a commitment to reduce a certain amount year on year. We are on course and on track to deliver the savings commitment this year that we said we would deliver.

We are currently going through a significant reshaping of the organisation. We have already looked at the senior structure of the organisation and reduced the size of the senior structure. That piece of work has completed. We are moving early in the new year to the next stage of the reshaping, which is the more junior structures across the organisation. In doing that, we are developing a new operating model, which will enable us, as we have talked about earlier in this hearing, to think about how we triage cases, how we process them in the most effective way, how we make sure that we are using our most experienced resource on the most complex cases. As we move through that piece of work, we will be able to set out more clearly the sorts of resources that we will need to deliver the demand that is coming to us and how we can do that in the most efficient way possible.

Q84 Ronnie Cowan: I wonder how you can leap ahead and say, “We are going to make 24% cuts” and then we see you can work up the figures to come to 24%.



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Dame Julie Mellor: All our plans are incorporated into our business plan each year. Our business plan this year and the budget that we set would outline the £3.1 million that we will be saving this year. We have made clear when we submitted our plans to the Treasury what it would be, as Amanda said, each year going forward. We have achieved this year. There are plans in place for next year and, indeed, the plans that Amanda is alluding to will also impact upon savings in further years, but obviously you refine those each year. We have taken a very normal and proper planned approach, but you are looking perplexed.

Q85 **Ronnie Cowan:** Yes. I am looking for the detail behind this 24%. Where is the 24% going to come from? I would have expected to have seen that broken down into smaller chunks, "We are going to save a percentage here and a quantity here".

Dame Julie Mellor: This year, I can tell you specifically where the £3.1 million has come from. It has come from accommodation savings, the introduction of hot desking and having fewer floors. We put in a chunk for contingency because we had never made savings of this scale before.

Q86 **Ronnie Cowan:** What I am getting at is that is with hindsight where you have saved. You have projected ahead you are going to save 24%, so I would have thought at the outset from day one you would have been able to say where that 24% savings was going to come from.

Amanda Campbell: We have a breakdown across each aspect of the business and where we need to make the savings across the operations, the external affairs and insight across our—

Q87 **Ronnie Cowan:** Has that been published?

Amanda Campbell: It is not a published plan because that is for us, therefore, to develop and to make sure that we deliver the savings against that.

Q88 **Ronnie Cowan:** Okay. Why, given that, has your expenditure this year gone up?

Dame Julie Mellor: Expenditure has not gone up.

Ronnie Cowan: Apart from one accounting adjustment for an erroneous lease, expenditure has gone up.

Dame Julie Mellor: We will be making savings of £3.1 million this year.

Ronnie Cowan: That is not the information I have been supplied with.

Dame Julie Mellor: Over the spending review period, our budget will go from £32 million to £26 million. The savings in year are different to a straightforward that going down, partly because of accounting measures like the onerous leases, but also because there will be one-off costs that are investments to save. There will be costs that could be for redundancy. For example, this year we have introduced the casework



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management system that will make our casework more efficient, but the benefits are further down the track.

Q89 Ronnie Cowan: On that point, is that why the last two years the cuts are 20% and 30%?

Dame Julie Mellor: What is two years, 20%, 30%?

Ronnie Cowan: The spending cuts planned to take place in the two years are 20% and 30% respectively.

Dame Julie Mellor: The savings in the last two years of the four-year period are planned to be £2.1 million and £3.1 million. Over the whole four-year period it will amount to 24%. What is being planned at the moment, because there are different cuts being made in different areas, so we expect to make further significant reductions in the cost of accommodation. As Amanda said, we have agreed in principle a new operating model, which we are working with staff on developing in detail, which will introduce even more efficiencies into our casework. Different teams across the organisation are looking at how they could save different amounts of money over a period of time so that we can then make decisions at the board on which savings we want to go for. The budget for next year will be in place following the March board meeting when we formally agree the budget.

Q90 Dr Dan Poulter: Just a few questions on your staffing arrangements. Now, 84 of the 340 staff in operations are on fixed-term contracts. Why do you continue to employ so many temporary caseworkers?

Amanda Campbell: We recruited a temporary project team to deal with the previous backlog that is discussed in this annual report for 2015-16. Those were to deal with the 2,000 cases that were outstanding at the start of that year. They were recruited on fixed-term contracts because the intention was to clear that backlog, to reduce all backlogs to zero and then to not need temporary resource going forward. As Julie has explained, that team cleared the big backlog of cases that were in existence, but because of various recruitment issues, either losing some of the temporary staff but also attrition among the permanent staff members, a further queue was allowed to build. We both recruited more temporary officers and extended the length of some of the temporary officers that were with us until the end of March 2017. The intention is that we will use the temporary resource to help us get back to a sustainable position by the end of this business year and that we will then have sufficient permanent resource in place in order to meet demand going forward. It is a short-term issue to deal with backlogs.

Q91 Dr Dan Poulter: How do you ensure that your staff, and particularly the temporary staff, are appropriately trained when they are handling investigations?

Amanda Campbell: The temporary staff coming in go through the same training as the permanent staff members coming into the organisation.



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What we did was bring in temporary staff with the intention that they would be focusing on the less complex cases, so triaged cases where they were more straightforward for them to deal with, and to deal with them at the beginning of their recruitment at the assessment stage to decide whether a case should go forward for a full investigation or not. Obviously, as some of those temporary staff then stayed with us for some considerable time, they moved on to develop the skills and to be trained in order to conduct some investigations, but again at the less complex end of the scale. Their work is supervised by more senior staff and by investigation managers. They will be conducting the same work as other members of staff, permanent members in the organisation, but of lesser complexity.

Q92 Dr Dan Poulter: I presume from your answer there that if people have been in the organisation for longer they will tend to take on some of the more complex cases?

Amanda Campbell: For those that have they will, yes. We have obviously a range of permanent staff members that have been with us for a number of years who are highly skilled in very, very detailed and complex investigations.

Q93 Dr Dan Poulter: Four executive board members have left the board in 2015-16. How has that impacted on the effectiveness of the board?

Dame Julie Mellor: That is a good question. I think the lack of continuity in the senior executive positions has had a profound impact upon the scale of work that the executive team can undertake. Obviously, that shows in terms of the work of the board as a whole. I actually think one of the other effects that we are both concerned about is the impact that that lack of continuity has on staff morale because staff are getting on with delivering a service but without the continuity of senior people in place and the continuity of leadership. I think that is probably where the impact has been greater.

Q94 Dr Dan Poulter: Okay. Just looking at the general issue of staff turnover, 23% is the rate of staff turnover in the organisation, which is much higher than the 14% public sector benchmark. Why do you feel that is the case?

Amanda Campbell: I think that is down to the recruitment of the fixed-term contract temporary staff. Obviously, as those contracts have naturally come to an end we have seen a greater turnover in the organisation. If you remove all of the fixed-term numbers out of the equation, I think you will find the figure is much more comparable in terms of standard attrition to the other benchmarks.

Q95 Dr Dan Poulter: On that issue, you have talked about a backlog of cases, but there is also a concern about the six-month benchmark, about the time it has taken to meet that. You are currently not meeting that standard and, from what you said, were not expecting to meet it again this year in terms of 95% of cases being dealt with in a timely manner,



within six months. How do you feel that staff turnover impacts upon your ability to address and deal with some of those cases at high level, notwithstanding the issues you have just raised?

Amanda Campbell: I think it certainly has had an impact on the organisation's ability to deal with cases in a timely manner. We have, as Julie reflected earlier, had a situation earlier in the year where we were not recruiting enough people and not recruiting them quickly enough. We have resolved that issue and we are now bringing more people into the organisation, but it definitely did have an impact earlier in the year. What we do know now is that if we look and compare the current figures to the figures in 2015-16 published in the report, we are getting faster at dealing with cases. We are seeing an uplift in the speed of throughput of cases certainly at the earlier stages. I think a really important one is we have a throughput measure that is about how many cases are dealt with within three months, within the 13-week period, and we have had a 16% rise in the numbers of cases dealt with in that three-month period over the course of the last six months. That is really important because we talked earlier about people wanting justice more quickly. If we can resolve cases in a much more timely way in those very early periods, it means we can focus the more complex cases and take longer on those. The process is definitely getting better. We are certainly not near to where we need to be overall, but I think earlier in the year the impact of the staff attrition definitely did impact on queuing and waiting times.

Q96 **Dr Dan Poulter:** I am quoting now, "Realising the full potential of our staff to contribute to the success of our organisation" is one of your six aims for this year and next, yet compared to last year your staff turnover rate has increased by 5%. I accept that there may be an issue that you have already touched upon with the temporary workers, but notwithstanding that, if you take, say, 5% as being the explanation away from the 23% of staff turnover, that is still substantially above the public sector average of 14%. I am just trying to drill a little bit further into why there is such a high staff turnover because it cannot all be explained, from my reading of the figures, just by the temporary workforce that you are employing to deal with the backlog.

Amanda Campbell: There are a number of factors at play here. As we have talked about, a complete change of the executive of the organisation and the various issues that have happened throughout the course of the year clearly have a real impact on staff. You will have seen the details of our most recent staff survey, which was conducted earlier in the year. What that data shows us is that 85% of the staff in the organisation are committed and passionate about the organisation and want it to do well. What that data also tells us is that they do not have the confidence in the leadership of the organisation. They did not see the leadership of the executive as visible, so we are doing something about that. We have looked at what that data is telling us and we are shifting the way we operate to respond. Certainly, the executive team, myself and my executive colleagues, are out in the organisation talking now to



our staff about the future. We are involving them in the changes. I think there was not enough of that before. We did not do enough of involving people.

It is also important to note, though, when you look at our staff survey results that while overall the numbers are low and we need to do much better, quite clearly, there are certainly some green shoots in terms of things that are now being done in a better way and that will give staff more confidence about the organisation and working in the organisation. So, some real uplifts in things like communication across the organisation, in how the organisation works together, a 42% uplift in people co-operating and working more closely together across the organisation, and a 21% uplift in morale, people being asked about the morale of the organisation. They are from a very low base. I am not claiming victory about this. What I am saying is we have a lot to do. We have to involve our staff more. We have to talk to staff more about the changes we are making. We have to involve them and get them to help us in what we need to do, but it is a workforce that is totally committed to what we do. They want it to succeed and they want the organisation to be the best it can be.

Dame Julie Mellor: If I may go back to your question, I think what I am hearing is that you are concerned about our ability to meet demand on a timely basis and a kind of hypothesis that high turnover may be partly the cause of that. I think there is another cause that I mentioned earlier, which is we underestimated the number of people we needed. One of the things that we are doing to address that is for the first time, because we are now a high-volume service, we are taking a scientific approach to track and predict demand and calculate the resources required. That then feeds into informing our workforce planning so that where we know turnover and we know demand we can look at how many people we need to recruit and how regularly in order to be fully resourced to meet demand on a timely basis.

Q97 **Dr Dan Poulter:** That is helpful, thank you. The staff survey, which you have talked about, shows that the longer that staff have been employed in the organisation the lower is their morale. How would you explain that? It sounds quite counterintuitive.

Amanda Campbell: I think part of that is because of the degree of change that has happened in the organisation over the last few years. As we talked about earlier, we have gone from being an organisation that was very paper based, that worked in a particular way, that did investigations on paper and responded in correspondence, to shift to a completely different service model where we have asked our staff to behave in a very different way than previously. As we also talked about, we have made these huge changes, more justice for more people, more impact, but we did not put in place all the underpinning in the organisation or the organisational processes to support that in the way that perhaps we should have. So, it is not surprising that staff that have



been there for a long time have experienced all of that upheaval and thought, "I am not very happy about this", whereas new people coming into the organisation that are seeing the new have only experienced that and have not had to go through that change.

It is disappointing but understandable that our staff that have been there longer feel that way. My job and the job of the executive team is to shift that back again and to get us to a point where everybody in the organisation is feeling as positive about it as the more junior staff.

Q98 Dr Dan Poulter: My last question to you I suppose touches on that answer and also an earlier answer you gave. In response to last year's scrutiny session, I understand that you highlighted initiatives to improve the communication between the leadership and the staff within the organisation. You have made similar commitments this year. In spite of this, the lack of engagement with the organisation's leadership remains a key concern to staff. What assessment have you made of the effectiveness of some of the staff morale-boosting initiatives that you have spoken of?

Dame Julie Mellor: Perhaps I can come in on this one because I would like to thank our staff for continuing to deliver the service given the lack of continuity at the top of the organisation, which will have affected how they felt. I think that lack of continuity has made it much more difficult to increase the visibility of the leadership and for the leadership to engage with staff because we have had that turnaround over the year. That is why the green shoots are in the areas where we were able to take action, which were around communication and working differently across the organisation.

I would say that when I stepped in briefly as chief executive when our managing director resigned I was acutely aware of the previous staff survey results. The first thing I did was sit down with groups of staff. I think over a few weeks I met about 120 staff in small groups to listen and find out what was concerning them and then took action in the areas that they raised with me with the rest of the executive team. That was a concrete action that I took during that period and those things have now continued. For example, some of those roundtables have continued. We now have the weekly communication to staff on what has happened, what the executive have been spending their time deliberating on and deciding and moving forward. That is something that Amanda and her team have continued; 96% of staff say they read it and find it useful.

I introduced a very simple approach, which I wrote to the Committee about, to make sure that whenever we were introducing change we did it in a way that involved staff. We would be looking at what it was we needed to change and why and then involve staff in how we do that before then making the changes. That was something else that we did. We also introduced hot desking. Partly it reduced costs and partly it meant we were moving around where we sat more. Again, one of the



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things staff asked me to say to you was that their confidence in the executive team is growing because now it is stable it is more visible.

Kelvin Hopkins: We have come to the end of our questions and it has been a very long session, for which we must thank you for subjecting yourself to this. I also thank you both for coming today to appear before us formally. Amanda Campbell we shall be seeing again in future, no doubt, but it is possible we may not be seeing Dame Julie again, in a formal way at least. I am sure you will be meeting the Chairman and some of us informally. To echo what he said at the beginning, thank you in particular for carrying on during this period of interregnum until your successor is in place.

Dame Julie Mellor: You are welcome. Thank you.

Kelvin Hopkins: So, many thanks. That is the end of the meeting.