

Public Administration and Constitutional Affairs Committee

Oral evidence: Parliamentary and Health Service Ombudsman Scrutiny 2017-18, HC 1855

Tuesday 22 January 2019

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Members present: Sir Bernard Jenkin (Chair); Ronnie Cowan; Kelvin Hopkins; Dr Rupa Huq; Mr David Jones; David Morris.

Questions 55 - 125

Witnesses

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

Written evidence from witnesses:

- [Parliamentary and Health Service Ombudsman](#)

Examination of witnesses

Witnesses: Rob Behrens and Amanda Campbell.

Chair: I welcome our two witnesses to this annual scrutiny session of the Parliamentary and Health Service Ombudsman. Could I just ask you briefly to identify yourselves for the record, please?

Rob Behrens: Rob Behrens, Parliamentary and Health Service Ombudsman.

Amanda Campbell: Amanda Campbell, Chief Executive.

Q55 **Chair:** We have quite a number of questions, which we will ask briskly, and if you can keep your answers reasonably precise that will help us get through what we need to get through.

I will start with a question about your new strategy or three-year strategy, which you published in April 2018, which has three principal objectives: to improve the quality of your service, to increase



transparency and the impact of your casework, and to work in partnership to improve public services, especially in complaint handling. How is the implementation of this new strategy progressing?

Rob Behrens: It is going well, Chair. The important thing about the strategy is that it was carefully consulted on before it was implemented. It takes our service back to basics—the quality of our decisions, transparency being outward facing and developing more skills in frontline institutions.

In the strategy we made 17 explicit commitments. We have made progress on all of those commitments. The strategy is clearly understood and supported by our staff and many stakeholders, and it is being delivered alongside significant restructuring of the organisation to make us more efficient and to meet our 24% funding cuts.

As you know, in the view of the independent peer review panel, it is being implemented decisively but that is only so far. We have only completed one year of it and, while we have made progress, we have a great deal to do to become the exemplary ombudsman service we need to be.

Q56 **Chair:** You said you had consulted on it. How did you consult on it? Whom did you consult and what changes to the strategy emerged from that?

Rob Behrens: We consulted throughout the process of constructing it, not only with our staff but with the public. There was a significant series of responses that were integral to allowing us to understand that we had to go back to basics in order to win the trust of our stakeholders.

Q57 **Chair:** What impact has it had so far?

Rob Behrens: The strategy is part of our rebuilding exercise. It is, first of all, as you will see from the staff survey, understood and entirely supported by all our staff. You cannot deliver a strategy like that unless you take your colleagues with you, and I think that is a key element of what we are trying to do.

We know that we had been behind the line in terms of our case handling procedures, and we have put a lot of effort into trying to improve the professionalism of our case handlers—and that is a three-year project—through a comprehensive training programme, through accreditation, through changing and simplifying the way in which we handle cases to make sure that one person has responsibility for taking a case through. We cannot win trust without transparency. This is absolutely key. We have an ambition that we will deliver to publish almost all the cases that we handle at the end of the process, and we have talked very carefully to Mick King, my counterpart in local government, to see how they did that.

Critically, far too many cases come to us that we cannot actually deal with because they are premature or out of jurisdiction. We have



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something like 120,000 inquiries, and a great deal of those inquiries are not appropriate for us to deal with at the time, so we have to give advice to people on where to go and who to consult.

What this means for me is that we are spending too much resource on telling people to go somewhere else, but we also—and this is fundamental—are the ombudsman of last resort. What the strategy argues is that we have to work with frontline organisations to help them improve their case handling so that fewer people come to us and we only deal with the complex cases. That has had a good resonance across bodies in jurisdiction.

We may come on to this later, Chair, but there is a seething desire in frontline bodies to improve their own complaints handling process, and they believe that we can help them do that. But we know that we can only be part of the process to help them because we don't have significant resource to take it on our own.

Q58 Chair: You say you spent too much on advising people how to pursue their complaint elsewhere, but is that not money well spent in the public service? I hear you say your bodies in jurisdiction should be dealing with these complaints more effectively but, in the absence of very effective complaints handling, aren't you providing an essential service?

Rob Behrens: We are providing an essential service, and I am grateful to you for pointing that out. If some of the frontline bodies were better, they would be able to deal with cases without people coming to us and I think that is an issue.

The other issue, of course, is that if there were a clear pathway to come to a national ombudsman, which there isn't at the moment, that issue would be simplified. What I find, in talking to my counterparts in other countries, is that it is simply not an issue to get to the ombudsman there in the way it is in this country.

Q59 Chair: If you are effectively running a complaints advisory service, shouldn't we be making a pitch for that aspect of your operations, inadvertent though it is, to be properly funded?

Rob Behrens: Well, that is right, and I agree with that. I note that that is the comment made by Peter Tyndall in his report—that too much emphasis has been put on formal investigations and not enough on the good work that we are doing in helping signpost where people need to go.

Q60 Chair: What are the other challenges that face you implementing the strategy?

Rob Behrens: I think I said in my pre-appointment hearing that what I was undertaking would be like playing the piano and moving it upstairs at the same time, and I think that is absolutely right. What we have had to do is transform our operations and deliver our service at the same time.



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In the last year, we have made significant progress in transforming our operations, specifically by moving our key operations to Manchester. That is a very big enterprise.

It has meant that we saved a huge amount of money to put into our frontline operations, but it has meant that 100 posts were transferred and a number of people could not or would not move to Manchester, so we have had the HR issue of making sure we were properly resourced. We have had to recruit a whole tranche of new, young graduates from the north of England to work in our Manchester office. That inevitably was a challenge for us because we lost experienced case handlers as a result of the move. That is why we have put so much investment into the training and professional development of our case handlers, to make sure that they have the support that they need to do a very difficult job.

Could I just say one other thing? We have had to rebuild our relationships with external stakeholders and we have made a lot of progress in doing that, particularly in the ombudsman world where there had not been much contact before I came. I think the independent peer review is a sign that we have re-engaged with the ombudsman community and that we are learning lessons from our counterparts in a good way, but we still have a lot to do with bodies in jurisdiction. Amanda and my colleagues are doing a lot of visits to understand what is going on in trusts and in hospitals and in other public bodies. So this is important, but it is only a beginning to the process.

One other point, we have made a lot of effort—insufficient but a lot of effort—to talk to complainants about cases to make sure we understand what the issues are. The concept of the open meeting, which I introduced, was something that was not used by the Ombudsman Service. That has been extremely successful. I have had dozens of meetings with individual complainants to talk about their cases, and we now have a regular interface with the community through Radio Ombudsman, which has a large number of hits across the world.

Q61 Ronnie Cowan: I am interested in that last point you made there because that to me is the crux of the whole matter. I have had correspondence from people who have felt let down by the system, not just once, not just twice but every single step they have tried to go through. A lot of them are health cases, which are obviously very emotive. For people who have been looking for health care for friends or family, for loved ones, and for the WASPI women in their campaign, they feel as if they have run into a bureaucratic nightmare and no one is listening to what they are saying, but now you are telling me—*[Interruption.]*

Chair: Order.

Ronnie Cowan: I am glad to hear you are now telling me that you are talking to individual people. How do you select who you are going to go to talk to?



Rob Behrens: I am not just talking to individual people, Mr Cowan. I am talking to a whole range of people in a whole variety of meetings. There is a legacy of distrust, which I have had to take on board and to address. I am not saying to you that in the 18 months that I have been there that has been solved; it is a significant issue.

Everything that we have done has been based on the idea that when people have, for example, a health complaint they may be legitimately distressed or bereaved or traumatised, and what we have done through our training process is to give people the skills in our office to understand that this is routine, that they have to deal with people as individuals and there is no point in trying to stick to a bureaucratic approach to these issues. We have a lot to do in order to deal with this. When someone asks for a meeting with me, I am inclined to accept it and I do have those meetings and that is extremely helpful.

Q62 **Ronnie Cowan:** When you say the complainants may be distressed or traumatised, you actually implied that they might not be in full possession of the facts or they are letting their emotions run away with them and forgetting the care that their loved ones did get.

Rob Behrens: I can draw your attention to Scott Morrish who spoke at our annual open meeting most movingly. He has talked to me. He is going to be involved in our future training and development programme. He explained that in his case, which was awful, the problem was that our case handlers were traumatised by his trauma and their inability to do anything about it because they did not have the skills. That is a professional issue that we are addressing in our training programme. We have to be more emotionally intelligent to deal with those cases on a daily basis.

If you are asking whether people have full understanding of the facts in their case, my experience is that most people are very well informed about their own individual case, but that is not a substitute for the ombudsman making a decision about the appropriateness of the complaint.

Q63 **Ronnie Cowan:** You also mentioned a backlog here. It sounds from what we have heard like there is a bit of a basket case. You have a backlog of cases here. Is there anything you are specifically doing to clear away that backlog, to clear your feet, so that you can then move forward?

Rob Behrens: We have addressed that, and I will ask Amanda to tell you explicitly what we have done.

Amanda Campbell: Thank you. You recall when we came before you last year I talked about things getting worse before they got better. We were putting into place this enormous training programme and, as a result of that, clearly with lots of time being taken out for training for staff members, we were not able to deal with as many cases.



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By January last year—so this time last year—we had a backlog of 2,100 cases. What that meant was that people were waiting a very long time to access our service, so we have worked very hard over this past 12 months to reduce that backlog of cases and make sure that we have allocated every case that was in that queue to caseworkers to deal with. From the end of October, the backlog has been reduced to frictional level, so that is just the amount of work that comes into the office every month and is allocated every month.

For people going forward using our service, from October onwards, they can expect their case to be allocated to a caseworker within a month, and all of those historical cases are now with caseworkers and being worked on.

What that does mean, of course, is that some of those people have been waiting a very long time and so, while their cases are being considered now, they will take some time to move through our system, but newer cases coming into the service are coming in and meeting service standards.

Q64 Mr David Jones: Mr Behrens, the independent peer review assessed the position of the PHSO rather colourfully as moving out of “critical care” and into “recovery”. What do you understand by that and to what extent do you agree with that assessment?

Rob Behrens: I think, first of all, it indicates that we have turned a corner, in terms of progressing the organisation, but it is not a basis for complacency or for sitting back. One of the reasons why we commissioned a peer review was that we felt that the people on the panel would have an intimate knowledge of the ombudsman process in a way that management consultants, in my experience, do not.

I particularly valued from the panel their suggestion that we were doing well, that the staff were supporting what we were doing, and we were having an impact, but there were still significant things that we needed to do in order to make progress. Part of that was about the mandate that we have, and so those are issues for Parliament. Also, there were operational issues that they pointed out that we needed to address. They include the need to have less oversight of frontline complaint handlers, the need to address our IT system, which Peter Tyndall did not rate very highly, the need to ensure that appropriate specialisms are not lost in the move to generic teams, which he supported, the need to continually champion ombudsman reform, and particularly the need to move towards resolution of cases rather than formal adjudication.

As you will see from strand one in our strategy, there are measures there to promote early resolution and mediation, to try to get away from the idea that all cases have to be adjudicated on. You cannot do that overnight. That is about continuing professional development. We need to find people or to equip the people we already have with skills about mediation and early resolution, so that we do not have to pay vast



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amounts of money to people to come in to do the mediation. So I am encouraged by what the panel found, but I found it to be stimulating and valuable in terms of their insights.

I will give you another example. Tyndall pointed out that too much emphasis has been put on what the office does in terms of formal investigations, which tends to ignore what we call something else in terms of looking at cases. What is the term?

Amanda Campbell: Assessment.

Rob Behrens: Assessment. In other ombudsman organisations, assessment would be termed adjudication and he said we should not misunderstand the work that we do as far as that is concerned. That was one thing.

The second thing that he said was that, when we are looking at value for money, we need to bear in mind that a large proportion of our cases are health-related and those are more expensive to deal with because of the clinical advice that we are dealing with. As you will remember, he was cautious about accepting formal statistical evidence about value for money because of the differences in jurisdiction between us and other organisations. So I take what he said as being extremely valuable and helpful but also critical in terms of challenging us to move forward.

Q65 **Mr David Jones:** You have clearly found the review process to be useful. Do you feel that it maybe ought to be repeated on a semi-regular basis as Mr Tyndall suggested?

Rob Behrens: I agree with that absolutely. The process of peer review is fairly new in the ombudsman world and, interestingly, the International Ombudsman Institute has asked the UK to host a seminar later this year to look at how to do peer review, and that includes how often you should do it. Clearly we do not want to do it so often that it becomes a burden but, I agree with Peter Tyndall, perhaps every three years or three and a half years. That would be a good discipline for the organisation to subject itself to.

Q66 **Mr David Jones:** Is that something you would wish to put in place?

Rob Behrens: Absolutely.

Q67 **Mr David Jones:** As you know, there has been some criticism about a lack of independence in the peer review process. The review was conducted by an ombudsman assisted by a panel who also had a background in ombudsman services. You have told us just now that you regarded that as more valuable than if a management consultant had been approached, but do you think maybe the involvement of a management consultant might have made for more independence in the process?



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Rob Behrens: No. I think that the decision about who the panel were was a decision for the chair of the panel. It wasn't for us. I heard what Peter Tyndall said about that. I think it is sensible to look at the composition of a panel but, in my view, the idea that the President of the International Ombudsman Institute is not going to be independent is not really credible. I do take the point that there might have been a member of the panel who did not have any formal connection with the ombudsman world, although Chris Gill is a distinguished academic. He is not an ombudsman any longer.

Q68 **Mr David Jones:** No, but he had a background in the Scottish Public Services Ombudsman.

Rob Behrens: Yes, absolutely. I should make the point also that management consultants use former employees of the organisations that they scrutinise in order to give them credibility in what they do. But I accept your point and I think it is all part of the issue of developing the ways in which the ombudsman world looks at peer review, and I am confident that we will come up through the International Ombudsman Institute with a methodology that will address the point that you make.

Q69 **Mr David Jones:** It is not just a point that I am making. As you know, concern has been expressed by others that—at least in terms of optics—to have one ombudsman effectively investigating and commenting on the work of another ombudsman looks, in terms of optics, as I say, rather culturally cosy.

Rob Behrens: I don't accept the term "culturally cosy" at all. I think that is inappropriate. In a difficult position, we commissioned the best available experts to look at what we did and they were extremely critical of the situation before I came to the organisation. If it had been cosy, they would not have made the critical remarks about the organisation before Amanda and I arrived.

I understand the point that you make. It certainly wasn't cosy. It was cost effective. It cost a very small amount of money, and it was us who paid and, therefore, given the constraints we were operating under, I think they did an outstanding job.

Q70 **Mr David Jones:** Did any of the panel's conclusions surprise you or were there any that you would question?

Rob Behrens: I do not think it is for us to question what they came up with. We put ourselves out to scrutiny. They had the opportunity to look at the books. They met with any staff who wanted to meet them. They went around the office. It was a full and open disclosure, and I was quietly satisfied that they understood the challenges that we were operating under and did not underestimate them.

Q71 **Mr David Jones:** None of their conclusions caused you any surprise?

Rob Behrens: No.



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Mr David Jones: Thank you.

Q72 **Chair:** Moving on to the Miller case. Did the Miller case come as a surprise to you?

Rob Behrens: No, sir, but Amanda will take that on.

Amanda Campbell: The case was reported from the Court of Appeal at the beginning of last year, in February, but it was actually a case that had originally come to the ombudsman back in 2012 so it had been a very long time in the system.

The key finding of the Court of Appeal was that the standard that we were applying, in relation to clinical judgment, was not acceptable. It wasn't clear to clinical professionals how we were measuring and comparing the treatment that they were giving.

Q73 **Chair:** The judgment was actually that the standard you had adopted was: "beguilingly simple but incoherent", "unreasonable and irrational", "cannot provide clarity or consistency of application to the facts of different cases" and they even said, "It runs the risk of being a lottery dependent on the professional opinion of the adviser that is chosen". This is 80% of your casework, clinical cases, and this must have come as a bit of a blow.

Amanda Campbell: Well, we took immediate action following the court's findings and devised a new standard, which we then published later in the summer, that set out very clearly how we would assess clinical good practice and, essentially, how we would first ask those clinical professionals, who were dealing with health cases, what guidance and what guidelines they had relied upon in making their clinical judgments. Clinical advisers would then do an assessment again of the same standards and guidance available for the particular type of case, so it was clear that we were looking at both what practice had been used, where there had been deviations from that practice and why, and we would listen to the clinical professionals about the reasons for that. Then we would ourselves look at the clinical standard, the NICE guidelines and so on, and ensure that we were being clear about the judgments we were making against those standards.

We articulated the way that we used clinical advice, and we set that out publicly and published the way that we would do that going forward. That was obviously the key finding of the case, but there were other case-specific issues in that judgment that we also accepted had wider applicability to our casework. A number of those issues raised in the case were things that had already changed over the passage of time of the number of years since that case had come to us but there were others, such as predetermination.

So the way that we issued draft reports appeared to be predetermined. That they didn't actually give people the opportunity to say, "I don't agree with this. I don't think that you have used the right judgment". So



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again we changed the process of those reports to make it very clear when we put out our provisional findings, our provisional views, that they were provisional and subject to change, and that we would take on board input from both complainants in the case and the clinical professionals that were part of the investigation.

Q74 Chair: What about the unfair withholding of evidence from GPs being complained about? What have you changed in your procedures about that?

Amanda Campbell: There were some very case-specific issues to that case, but what that caused us to realise is that, when we write out to say that we propose to investigate, that was seen often as just a notification that we were going ahead. Therefore, we have taken the step of writing out to individuals—including named individuals—in those cases and then pausing and giving those individuals and those involved in the investigation the chance to come back and tell us their views about our proposal to investigate.

There is also an issue about material evidence and the fact that we did not always share the evidence that we obtained in cases, the evidence that was material to the judgments that we were going to make. Again, we have changed that so that now, if there is material evidence and individuals—either complainants or clinicians—wish to see it we can share that with them.

Q75 Chair: Turning back to the main finding, how is the new standard changing the way you actually make decisions about cases?

Amanda Campbell: It is giving, first of all, the clinicians that were involved in the clinical care the opportunity to tell us in advance what they relied upon: what type of guidelines, what experience, what research, so that we are very clear why they made the judgments that they made in giving the clinical care. We then use expert clinicians to look again at that care and the guidance that was relied upon, to make judgments about whether that was reasonable in all of the circumstances of the case?

Q76 Chair: Not surprisingly, we have had quite a bit of evidence from people who have drawn the conclusion from the Miller case that the ombudsman is not capable of making these assessments and judgments about people's clinical care. Of course, originally, the ombudsman was never designed to do that. What is your response to that?

Rob Behrens: Could I address that point? When I was appointed to become the ombudsman, I was clear that clinical advice is fundamental to addressing the issue of trust between the organisation and complainants. Before the Miller and Howarth Court of Appeal case I decided that we should have a review of the way in which we dealt with clinical advice, to make sure there could be public and complainant confidence in what we did.



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That is why we commissioned Sir Liam Donaldson as our independent adviser to take us through a project, which is coming to its conclusion, to address very carefully how our case handlers work closely with clinical advisers to make sure that we get appropriate decisions. That has been an extremely positive and consultative process. I am confident that, provided that we address the recommendations that Sir Liam has come up with, we will be able to go forward with confidence on this issue.

Q77 Chair: Are you developing a relationship with the new Health Service Safety Investigations Body, which is specifically established to conduct investigations into clinical incidents, and what kind of bilateral co-operation can you have with them to support your case handling?

Rob Behrens: It is fundamental that the ombudsman, who is not a regulator, works closely with regulators in terms of understanding what they do, sharing information and meeting often to deal with common issues in the health service. That is exactly what we have done with HSSIB. There have been a number of meetings with the leadership of HSSIB. I have been invited down to Farnborough to talk with their people. Amanda is developing a memorandum of understanding with HSSIB to make sure that we have clarity about what we are both doing.

As we said in our evidence to Parliament on this issue, we want to work closely with HSSIB and we understand that it has a key role to play here. We know that patient safety is intimately connected to the issue of service delivery. It is not quite the same thing as complaints handling and so there is space and opportunity for both organisations to behave professionally.

Q78 Kelvin Hopkins: In your evidence last year, you highlighted your ongoing concerns about the quality of local NHS complaints handling and the knock-on effect that has on the PHSO. Are you seeing any improvements?

Rob Behrens: No. I am concerned, on the basis of my frequent visits to trusts and hospitals, to meet in private with complaints handlers to discuss with them what they are doing. What they say to me in private is that they want help, they don't have the necessary resource, they don't have the appropriate status, and they don't have skills or training, which makes it very difficult for them to call into question the judgments of clinicians in hospitals. That should be a matter of concern for all of us.

One of the things that we set out in the third strand of our strategy is to work with the appropriate bodies, and bodies in jurisdiction, to develop and give incentive for one single framework of good practice in complaints handling for the health service and wider public service. Amanda has won significant support for this, and we hope to be able to deliver it towards the end of the three-year strategy.

Amanda Campbell: We have been doing a lot of research across the health sector about standards of complaints handling and about good



practice, and there are certainly pockets of excellence, but the practice is not consistent across the health sector. What we found is that there are actually different examples of good practice; that everybody is operating in different ways.

We have gone to a group that we are a member of, which is the Health and Social Care Regulators' Forum, which we also sit on with other ombudsmen. We talk to them about how collectively we all have an interest in improving complaints handling across the health sector and the wider public body sectors. Together—as Rob mentioned—we have agreed that we will do some work to, first of all, look at all of the different evidence of good practice, draw that together into a good practice framework and then set a standard that we can, first of all, encourage other people to apply. Also, as you will know from the evidence given by Peter Tyndall, there are opportunities to have a complaints standard that people are held accountable to. That is certainly something that a good practice framework could form the basis of going forward.

Q79 Kelvin Hopkins: What you both say is most interesting. Some 15 years or so ago, the Government introduced changes to complaints systems at local level. They abolished the Community Health Councils and I was one of those who had a suspicion that this was a deliberate attempt by Government to weaken complaints handling at local level—I do not know if you feel the same—and the suspicion was supported by the fact at that time. The Government tried to encourage private companies to come in and provide those services, and the private companies did not want strong complaints procedures that might make life more difficult for them. Do you feel that the Government are still reluctant to introduce strong complaints systems at local level?

Amanda Campbell: I don't think that is my experience. As Rob has described, there is definite variation in practice. There are examples, certainly in some of the trusts that I visited, where the board of that trust takes a very live interest in the complaints that come to them. The complaints are reported to the board on a regular basis and they use those complaints to build training programmes for their staff.

So I think there are examples of where people understand the benefits of complaints and that complaints give them the opportunity to improve and change the service that they deliver, but that is certainly not consistent.

Q80 Kelvin Hopkins: Do you get the impression that they are too close to the trusts themselves—they are part of the trust in many cases—and that they do not have the status to challenge clinicians when things go wrong? We saw the case of Mid Staffs Hospital, an absolutely appalling scandal a decade or so ago, which might not have happened had there been strong local relatively independent complaints handling that would have rung alarm bells at the time. Do you agree with that?

Rob Behrens: We know that improvements have been made in Mid Staffs and elsewhere, but my judgment is that the momentum for a more



effective incisive complaints handling service across the NHS has fizzled out, and we have to reignite that.

- Q81 **Kelvin Hopkins:** The local Community Health Councils were not strong but, even then, they were seen as an irritant to the local health authorities, health trusts. I know that they had a member always on the local board of the trust and there was always tension between the chair of the trust in my local area and the head of the local Community Health Council. They did not like being criticised by this relatively independent body.

You and the independent peer review have called for you to have a role in setting standards for local complaints handling. How would this make a difference, just standards rather than powers?

Rob Behrens: Yes. There is a good example in Scotland of my counterpart there having the power to establish good practice standards for public bodies, not only in the health service but wider. Although Scotland is different, and one cannot be too conclusive about it, the impact has been that local complaints handling, in terms of processes, has improved by the creation of these standards. I think that is a key issue for a Public Service Ombudsman Bill—going through Parliament in the coming period—to address. This is a once-in-a-generation opportunity to address the powers of the ombudsman. Becoming a complaints standards authority would not be resource-intensive. It would not have an impact on the decisions that are made, but it would enable us to encourage local bodies to be more effective in the processes that they use, so I am in favour of adopting it.

- Q82 **Kelvin Hopkins:** One last question. If cases on behalf of patients were pursued more effectively at local level, first of all, the families of the patients concerned, and patients, might be happier because their case would be dealt with more seriously at local level and resolved, hopefully, as well. It would also mean that you would not have to pick up the pieces at a later stage, often with great difficulty yourselves.

Rob Behrens: I think you are absolutely right. There is a huge amount of good practice that does take place. It is not particularly joined up in terms of powers, in terms of advocacy groups, in terms of HealthWatch England, who we are talking to, to make sure that we are operating together. The general principle is that if you can resolve issues on the frontline, that is a better way of dealing with them than allowing time to elapse so that they go to a second tier or third tier body.

Chair: Mr Cowan, you wanted a supplementary?

- Q83 **Ronnie Cowan:** Just quickly. Mr Behrens, you touched upon it there. You said there is a huge amount of good practice but, earlier on, Ms Campbell you said, "There are pockets of excellence". Are those pockets of excellence, and is this good practice in specific health boards that are better at doing their job or is it disciplines within medicine? Or is cancer care better than dementia or—



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Amanda Campbell: No. This is about certain health trusts who have put in place complaints handling procedures and a culture of using complaints as a good basis for system improvements, so there are examples of that in trusts rather than in specific medical disciplines.

Rob Behrens: We also know, sir, from the Titcombe case, for example, that one of the weaknesses was that professions in the hospitals were not speaking to each other about clinical issues. Midwives and doctors were not talking, and that was entirely detrimental to the health of baby. Amanda is absolutely right but, additionally, there has to be a joined-up approach to clinical care among professionals.

Q84 **Dr Rupa Huq:** Ronnie Cowan already hinted at backlog issues. The investigations were very much down last year compared to the year before, I think, from over 4,200 to 2,600, 37% fewer investigations but waiting times going up. What was the cause of that?

Amanda Campbell: As I explained, we spent a lot of the year implementing a significant change programme—transformation. We talked about relocating our main offices up to Manchester. That involved both a reduction of staff in London and recruiting large numbers of new staff to Manchester, and then obviously putting not only those staff but our existing staff members through a significant training programme.

We changed the way we work across very many areas to streamline our activities, but obviously any change needs to bed in and so, throughout all of that change period, cases were building up, and I talked about the very large numbers that we had last January. Because we invested over 2,000 days of training for our staff members over that period, those were days that they obviously were not dealing with individual cases, so the throughput did not happen.

Over the course of this past financial year, from last April through to now, we have seen significant productivity improvements. We are now closing more cases. As our caseworkers get more experienced, as our processes bed in, as our new staff become more familiar, we are starting to see those numbers rise and, as I said, the backlog has been reduced.

Q85 **Dr Rupa Huq:** That was a temporary blip, but you are more stable now with the move to Manchester?

Amanda Campbell: I talked about changing our processes, and one of the things that we are very keen to do is to make the right decision at the right time. Our past ways of working were very much on very formal investigations that often took a very long time, and we found that by spending a bit more time upfront in our processes we could often resolve issues for complainants without the need to move through to a full investigation. Rob talked a bit about that and our desire to do more early dispute resolution, more mediation, so we are starting to do more of those types of ways of working as well, particularly at the very early stages as people come to us.



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- Q86 **Dr Rupa Huq:** I know that, Amanda, you have called the average wait time simply unacceptable. We hear about the maladministration of the Windrush cases. It obviously raises concerns that this might happen here, and a lot of the WASPI women feel that the ombudsman is a bit of a dumping ground for complaints. You have said that you want to bring investigations down from 234 days to 200 days. Is that an ambitious enough target and when can we expect that to even happen?

Amanda Campbell: This current group of cases that were in a queue, some for a significant period, are now working through the system. The average length of time for those cases is quite significant. Overall, for cases coming into our service over the last year—the year of the report that is being scrutinised—the average case length time for people was about 154 days. For those cases that went to full investigation, it is considerably longer because, obviously, they have waited for a very long time.

We have a set of service standards and those are about throughput of cases coming to us. They are the number of cases that we would deal with within 13 weeks, within 26 weeks and within 52 weeks, and those are published service standards. What I can say is: for the cases coming to our organisation now—so from October onwards since we cleared the queue—all of those cases are now being dealt with within our published service standards, but we have this tail of very old cases that are now working their way through the system and those are going to take much longer.

- Q87 **Dr Rupa Huq:** With the new strategy—I know the idea is to speed up decisions—is there a worry about the quality being affected if it is processing people through; rush, rush, rush?

Amanda Campbell: The strategy is the right decision at the right time. What we did previously was take everything through, everything that we felt there was an issue with through to a full and detailed investigation, and those take a very long time. What we found is that a number of those can be resolved much more quickly, and so the individual complainant gets the right decision earlier than if they had gone through a more detailed investigation.

We are not looking at just speeding up everything. We are looking at the specific cases, what is involved in those cases and how we can give people a decision as soon as possible.

Rob Behrens: Could I just make the point that it is counterproductive to try to rush cases through in order to close them, because what that will result in is people being dissatisfied and then asking for a review because they believe that the case has been inadequately handled. The clear point Amanda is making is that we have to get it right first time. That means investing in the quality of our people and supporting them to do that.

- Q88 **Mr David Jones:** To what extent would you say that your work in 2017-



18 helped improve public services?

Rob Behrens: Ultimately, the role of the ombudsman is to do three things. One is to resolve individual complaints, and we did that for a significant number of people. We got hundreds of opportunities for organisations to improve their processes as a result of our investigations.

Secondly—and often this is missed—there is an issue about more strategic approaches to improving public service. One of the things we have done in that period is to produce three important reports that deal with systemic issues in public services in a way that I believe has made an important impact on improving them. The first was the report we did on eating disorders. There there has been a sustained reaction from the health service in terms of commissioning research and inquiries, to make sure they can implement the recommendations that we set out there on improving the standard, on the availability of expertise and on joined up processes in dealing with eating disorders.

I recommend that you listen to Claire Murdoch from NHS England—the mental health champion—saying how important our report was. She said on Radio Ombudsman that it was exactly the kind of incentive that the health service needed to improve its provisions, so that was one thing. The second thing was—

Q89 **Mr David Jones:** Let me just interrupt you there. I am pleased that she acknowledged the importance of the report, but has that report actually been translated into positive action?

Rob Behrens: It is being translated and we are waiting to see the final product of that. We are monitoring it, but there is significant progress taking place, which is well documented. I am happy to provide you with that material. It is substantive and it will make a difference. So that is the first thing.

In the mental health insight report that we did, we set out instances of human rights abuses in mental health provision. We did not make specific recommendations because the strategy had only just begun and we were looking at the issues, but we reminded stakeholders that human rights are not an issue just outside of the United Kingdom. It applies to people receiving health provision in England, and I think that had a sustained impact.

Then thirdly, as you know, we produced a significant report on fit and proper person processes in the health service. We were critical of the way in which senior directors in the health service were scrutinised in terms of whether they were fit and proper people. This is a very big issue. It will be looked at again in the Kark inquiry. We have made individual recommendations to one of the regulators, which they have accepted, and that will help to improve processes.

I am confident that, without being able to quantify it monetarily, we have made an impact in the year that you are talking about.



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Q90 **Mr David Jones:** Although the peer review panel said that it was difficult to quantify that impact.

Rob Behrens: Yes.

Q91 **Mr David Jones:** You said that you monitor responses to your reports. Is that a continuous process?

Rob Behrens: It is, absolutely.

Q92 **Mr David Jones:** How would you make decisions on prioritising resources as between casework and the wider systemic work that we have just been discussing?

Rob Behrens: Yes, I have been talking a lot about this with my international counterparts. I also want—and you may come on to this—the power of own initiative to supplement our systemic reviews because I believe that will improve our capacity not only to make public services better but to encourage individuals to complain.

My belief is that the two things support each other. For example, own initiative inquiries are just being implemented in Northern Ireland at the moment. I think they announced yesterday that they were setting out their first own initiative inquiry. They are using three people to conduct their first own initiative investigation. Peter Tyndall said it would have an impact on the resources but, if we had own initiative powers in addition to the systemic reviews that we do, that would not significantly take away resource from our individual complaints handling. I don't see that as a big problem. I think the issue is to make sure that you don't go on fishing expeditions; that you do things that are necessary and have a public interest and could not be done by someone else. There are a lot of regulators around, and it may be appropriate for them to do something that we might do, so that is why it is important to keep talking to them about what should be done.

Q93 **Mr David Jones:** How do you envisage that you would make decisions as to whether or not to conduct an own initiative inquiry?

Rob Behrens: I have been to talk with my international counterparts on this issue. There is a huge amount of expertise in the world, and 72% of my counterparts in the International Ombudsman Institute have this power. It is regarded as routine. There is a lot that you can learn. I have been to the Netherlands to talk to my Dutch counterpart. I have been to Northern Ireland to talk about it.

What happens, for example in Northern Ireland, is that the Northern Irish Ombudsman has a non-statutory protocol that sets out the steps that she must undertake before launching an own initiative inquiry, to make sure that it is not trivial, it is not something that just comes from a newspaper report or on social media but it is in the public interest and that she has the capacity to deal with it. I think in terms of public trust and trust of those people who have oversight of this, we should only undertake own



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initiative inquiries or even systemic inquiries if we think we can make a significant difference to the public benefit.

If we got own initiative powers we would not have them for at least two years, so we would have plenty of time to work through the protocols. It is not just about then going in and looking at whatever we wanted. It would have to be rigorous and disciplined, and we would have to consult with our partners to make sure we were making a difference.

Q94 Mr David Jones: Do you anticipate that such powers would ultimately translate into a reduction in casework because of the driving up of standards?

Rob Behrens: I won't be around to see that, but I would hope so. The ambition of the ombudsman should be to make sure that the number of cases coming is reduced as a result of all the good practice that is being implemented. That is a brave hope at the moment, but that is what we should be working for.

Q95 Mr David Jones: What progress have you made on publishing summaries of all your decisions?

Amanda Campbell: We are currently publishing just a small number of individual case summaries, but our ambition, as we set out in the strategy, is to publish the vast majority of our case summaries by the end of the strategy period. That is going to take a lot of work, not only to make sure that our technology systems are prepared, and you heard from Peter Tyndall that we have work to do to improve those.

The experience of the Local Government and Social Care Ombudsman, when it moved to publishing all of its reports, was that it needed to do a lot of work to improve the consistency and the appearance of its reports so that members of the public accessing them and academics and others knew how to navigate their way through the reporting. We have started that work. We have started the work to improve the way that we write reports, to simplify them, and also to make sure that they are more consistent, while at the same time working on the technology changes that we will need to make in order to move to full publication.

In the meantime, as I said, we are publishing individual reports. We have published two recently that relate to delayed diagnoses, in both of which we found that there had been avoidable deaths. One was a diagnosis in relation to cancer, and one was in relation to sepsis. In our intervening period, we are going to keep up the momentum so that we put out into the public domain cases that have much wider interest.

Q96 Mr David Jones: What impact do you anticipate publication of summaries of all your decisions will have?

Amanda Campbell: First of all, it will mean that members of the public can hold individual organisations to account, particularly in relation to the recommendations we make and whether those recommendations are



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followed through. There is the opportunity for research into the reports that we write, so people can use the information in the public domain to look at whether there are matters that are applicable across different parts of the system.

I also think another important benefit is to show where good practice is happening. At the moment, we publish reports when something has gone wrong, but there are also very many times when we investigate complaints where we find that organisations did a lot of things right, and that information never goes into the public domain. It is really important that people across the system can read those reports and see where there is good practice and where they might want to consider it too.

Rob Behrens: Your question is a very important one. Could I just add two points? One is that our service has been behind the line of its counterparts in dealing with the issue of publication. We have to accept that we have a long way to go in our strategy to deal with that, and we are dealing with it. The key issue for me is that when we publish our reports, we are demystifying what it is we do and helping to try to show people exactly what we have done and the reasons why we have done it. Not only with the individual complainants, but with people whom we want to encourage to use our service.

One of the big problems that we are addressing is that in this country public recognition of the ombudsman is less than 25%. When I talk to my Austrian counterpart, she has a public recognition rate of 70% in publishing her cases, in having state television weekly programmes there. It is important in terms of trust to be able to get people to understand what it is we do and what it is we cannot do, to make sure that we can take people with us.

Q97 **Mr David Jones:** Practically, how are the quarterly summaries you currently publish being used? Do you know?

Amanda Campbell: We have just started publishing quarterly summaries of all of our health cases. Again, it is to give members of the public the opportunity to see which health trusts have had complaints against them brought to us at the Ombudsman Service.

We are not yet publishing compliance against our recommendations, but we are considering how we do that, so that we can give people information on recommendations that have been accepted and whether those have been followed through.

Q98 **Mr David Jones:** Yes, but what evidence have you of what use has been made of these summaries?

Amanda Campbell: We have only just started publishing the information, so we do not yet have the empirical data to go back and say what use has been made of it.

Mr David Jones: Thank you.



Q99 **David Morris:** I was just picking up on a comment you made before about the powers you have and what you can investigate. You mentioned social media and newspaper reports. Do you find that you get a lot of frivolous referrals?

Rob Behrens: It is important to be aware of what goes on in the media and the social media. We have an intake team that deals with first contact in a highly professional way and talks to people about the issues that they are bringing to us. This is mostly telephone-based, and it is very interesting. We sit with them and we listen to what they have to do, and they have won awards for the way in which they handle the issues. That tends to take away issues that we do not think are relevant or appropriate for us to deal with. In my experience, I do not think frivolous complaints are really an issue for us because of the way in which the filter system operates.

Q100 **David Morris:** Do you have any examples? Obviously you cannot name a particular case, but can you give the outline of an example? If somebody did contact you and say, "I have seen this report in the newspaper or it has been on social media widely"; it has been reported, fake news, whatever. Do you have any recent cases that you could give the framework to that actually did happen, and were handled before they even got to a full-blown investigation?

Rob Behrens: Thank you. I think there is a wide misunderstanding that where there is a systemic issue, we could have a look at it because we are the ombudsman, whereas the limits on our powers at the moment are that we cannot look at issues unless an individual or a group complaint has been made about them. It undermines confidence in our service when people think that we are ignoring an issue, when in fact we do not have the capacity to look at it because of the legislative constraint.

Amanda Campbell: My experience of calls that come into our intake section are much more about people finding difficulty navigating the complexity particularly of the health system and knowing where to go when they have a complaint, or people who have gone forward to a certain stage in their complaint, and got nowhere and they do not know what to do about that.

As Rob said, we both sit with members of our intake team on an intermittent basis and listen to those calls. I was listening to calls a couple of weeks ago, and one of our intake case workers was dealing with a very, very challenging caller. He was having really great difficulty navigating the complaint system around mental healthcare, and particularly mental healthcare that involved deprivation of liberty. Our intake caller was having to support and help that person when the person was not ready to come to the ombudsman. It was a very real complaint that that individual had, but they just could not find a way through anywhere else. They come to the ombudsman and we help them to get to the right place.



Q101 Dr Rupa Huq: I have a question that might help demystify these processes that can feel like a maze and an obstacle course if you are the person complaining. In the interests of transparency, what has happened to the minutes of the meetings that used to be published? Board minutes used to go out quarterly, and there are none for 2018 anymore. They have all vanished. Again, it undermines confidence if that is not visible to the general public.

Amanda Campbell: I had not been aware that they were no longer being published, but I will certainly look into that and I will come back to you with an answer.

Dr Rupa Huq: It would be good to have an answer. Thanks.

Q102 Kelvin Hopkins: You have touched on my questions a little earlier but I want to be a bit more specific. You made 1,901 recommendations last year after upholding complaints. How many of those were implemented?

Amanda Campbell: We follow up with those recommendations that have an immediate response required. If, for example, we make a recommendation that somebody issues an apology—those are the vast majority of the recommendations that we make—or that somebody makes a financial award, we can follow up quickly and check that those have been implemented, and we do.

What is more difficult is when we recommend an action plan where activities will take place over a number of months. We do not go back then six months later or a year later to check that things have been done, because that would take us into the realm of regulation. What we do instead is say to those trusts that they should copy our final investigation reports and the recommendations we make to the Care Quality Commission, so that when the Care Quality Commission goes in to do its regular and routine inspections of trusts and others in the health sector, it can then look to see whether those recommendations have been implemented.

Q103 Kelvin Hopkins: Thank you. What progress have you made in assessing the impact that your recommendations have, and how do you publish that information? I appreciate the point about not being a regulator and so on, but on the other hand—

Amanda Campbell: What we can do and certainly do, for example, is on visits to health trusts we look back at the recommendations that we have made about those trusts, and then we talk to them when we go there about changes that may have been made as a result of our recommendations. For a particular trust that I went to, we had made recommendations in relation to an issue of information in its paediatric care unit. I was able to see that it had used that recommendation to change, quite critically, a function and some information and the need to check some information at a particular stage in the paediatric care unit, and that that had made a difference in ensuring that clinical professionals



were following a certain process. We can do that on an individual basis when we go to trusts, but, as I said, not routinely.

Q104 **Kelvin Hopkins:** There is obviously a resource implication, with 2,000 recommendations in a year, assessing their impacts. Is that a constraint, simply resource?

Amanda Campbell: We would like to do more, always. Part of the way that we become more impactful is by putting information out into the public domain so that members of the public and others who are interested in the work that we do can, again, hold organisations to account for the things that they have committed to do. There are some quite powerful ways of doing that as members of the public we see happening more regularly anyway, rather than needing the resources ourselves to do that.

Kelvin Hopkins: Thank you.

Q105 **Dr Rupa Huq:** The service charter has been established for a couple of years now. What are the trends in the figures telling you about what is occurring?

Amanda Campbell: We ask a number of questions in three main areas. One is a group of questions about, "Are we giving you the information that you need?" One is a group of questions about, "Is the process that we follow fair and open, and do you feel involved in it?" The third one is about the service that we provide.

What we have seen over the last two years is that the numbers do not change significantly. They go up and down slightly, but they have been pretty consistent over the course of the last two years.

The service charter is completely independent of PHSO. We have contracted a separate, independent company, and it goes out and makes contact via telephone calls with between 350 and 400 people a month, at all different stages of our process and at different points, to ask them what they think about that range of questions.

Overall, the majority of the people that it speaks to are positive, rather than negative, about the service. If we take, for example, the figures from 2017 in terms of, "Do we give you the information that you need", about 80% of people say yes—

Q106 **Dr Rupa Huq:** Is it a random sample? How are those—

Amanda Campbell: It is a completely random sample. The independent company has access to all of the people who have engaged with our service over that period, and it is able to select and make contact with them. Of all the formal investigations that are concluded in that period, about 25% of those people are made contact with, and then about 4% of all the rest of the people who come into contact with our service, which is over 100,000 people. About 2,000 people each time are contacted.



Q107 **Dr Rupa Huq:** Why do you think it is that the majority of complainants still think that you do not gather all the information that you need to assess their complaints? Those scores are low. What are you doing to address those?

Amanda Campbell: Those scores are much lower than I would want them to be. We have recognised that. The service charter information is examined on a regular basis by our Quality Committee. That is a group of both executive members of the team and non-executive members. We look at what the service charter data are telling us and then we decide what we will do to improve that.

The service charter responses have been a fundamental part of building our professional skills training programme. Some of the areas are about communication. It may be that we are doing some things in the right way, but we are not explaining those well enough. A big block of our professional skills training is about communication.

Another block of the training was about scoping an investigation and making sure that we really understood what individuals were telling us about what they wanted to be investigated, and that we agreed all of that with them before we proceeded with an investigation. The service charter forms a loop back into our training programme, and we will be training and developing our staff using that information over the years ahead.

Rob Behrens: Could I just make the point to supplement what Amanda has said? There are things that we should be doing better, and we recognise that. The service charter data that we have as an ombudsman are not equal to any other ombudsman service that we are aware of, so we are leaders in this field. We are not smug about that, but what we are saying is that this gives us an insight into what our complainants are saying that almost nobody else has, and that is very important.

Amanda Campbell: The other important thing to note is that within the service charter data, people's responses are influenced quite significantly by whether we uphold their complaint or whether we do not uphold their complaint. Around 49% of people say that they are satisfied with their service if we do not uphold their complaint, but if we uphold the complaint, 85% of people say that they are satisfied with the service that we give them. We have to look at all of this information in the round, but use it, as I say, to try to help support changes that we make to our service.

Q108 **Dr Rupa Huq:** Yes, it is pretty natural that if your outcome is favourable, you will think it is a good service. You suspended the consideration of complaints from the WASPI women and said that you would go for a sample. That also means that the sample you are picking to do the charter from is a sub-sample, because there are other people out there who are overwhelmed or whatever and could not deal with it, so it does raise suspicion—



Amanda Campbell: That is a different system. We were aware that there were many hundreds and thousands of ladies who had taken their complaints already to the Department for Work and Pensions and to its second-tier investigator. Those were starting to flow through to us in what were reasonably small numbers at that stage. What we did was look across the numbers coming in to us to say, were there common issues among those, at the time, 70 or 80 complaints that were being raised? From those, we identified a sample that we thought covered all of the issues in the complaints coming in to us so that we could look at those cases in detail and make recommendations about those issues that could then be applicable across the much broader group.

What we said was we would not proceed with the investigations across all of the numbers coming in to us individually. We would assess the cases, determine whether they had the same issues as the cases we had selected, and, if so, we would pause them so that we would investigate the six test cases, as it were. That is the process that has been followed historically in ombudsman cases in the past when very many numbers of cases come with a lot of common issues.

Q109 **Dr Rupa Huq:** As MPs, we sign off these things, and often it just feels like they have disappeared into a black hole, just from our end. As a Committee, we get a lot of complaints about delays and poor communication. I feel that if everyone had a chance to give feedback, that would be a good outlet for everyone. Do you know what I mean? You would buy good will as well if that mechanism were there. All WASPI cases are now on hold.

Amanda Campbell: The WASPI cases: there is lots of information on our website. We have written to all of the individual ladies who have brought cases to us to explain why those are on hold. That is because all of the issues concerned in this case are going to be tested in a judicial review hearing, and we have been advised that that is going to happen before the summer. We are not saying that we will not investigate; we are just saying we want to await the outcome of that judicial review hearing, and then we will continue to make decisions on those cases.

Q110 **Dr Rupa Huq:** It just feels unsatisfactory to a lot of people. Finally, the delays and poor communication: what is being done to—

Amanda Campbell: Again, that is back to the training that we have been undertaking. We have recognised—and I have talked at length in this hearing about—the delays that we have had in taking cases through the system, but those cases are all now allocated. We have responded to feedback that we have had about communication by building a training programme that deals explicitly with that issue.

What I should also say is that as well as complaints that I know come to this Committee, I also see on a daily basis notes and letters and email communications from people who have experienced a really good service from members of the team at PHSO and who take the time to write to



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thank us for the excellent communication and the service that has been provided. While I accept we do not get it right all of the time, we are working very hard to address that, but there are a lot of people working really hard and delivering a very good service.

Q111 Dr Rupa Huq: Last year the Committee recommended that as part of the service charter you ask complainants about whether they perceive you as impartial in your decision-making. How and when do you intend to do that?

Amanda Campbell: Again, those issues are often clouded by the decisions that we make, but we are going out to retender for the service charter very shortly. One of the things that we are going to ask for the new company or the company that is successful to do is to run focus groups independently for us. They invite people they make contact with to come in and give more detailed, qualitative feedback about their engagement with PHSO so that they can ask questions about impartiality and the impartiality of our service in those forums without PHSO being involved in asking those questions.

Q112 Dr Rupa Huq: Just a final one for Rob. I wonder, have you actually ever named and shamed any of these bodies that might refuse compliance? Has it happened yet? I know it is there as a sanction. Have you threatened it to anyone, if not?

Rob Behrens: Absolutely. This is fundamental to our credibility. I know this from my experience of being an ombudsman for 12 years. If you do not deliver when a body in jurisdiction does not accept your recommendations, then you have to take action to make it publicly known that those bodies are not implementing the recommendations. I am absolutely committed to that.

There have been one or two examples, which I prefer not to name, where we have come to the brink of that, but in the end bodies in jurisdiction savour their reputations and they do not want to be seen to be non-compliant. I do not like the term "name and shame". We have to publicise the fact that they have not complied with what we do, and we will do that.

Q113 Dr Rupa Huq: There are none that have been publicly known to have not complied? They have been told internally?

Rob Behrens: Not in the year that we are talking about.

Q114 Dr Rupa Huq: Maybe it is not enough of a "carrot and stick" then if nothing happens, if it is just informal.

Rob Behrens: No, it is not informal. It is important that you give people the opportunity to comply, and if they do comply, that is okay. If they do not, that is very serious, and I will act.

Q115 Dr Rupa Huq: It has not got to that point yet?



Rob Behrens: No.

Dr Rupa Huq: Thanks.

Q116 **Chair:** Moving on to your staff engagement, which has shown a pretty dramatic improvement from well below the civil service average to now above the civil service average. To what do you attribute this improvement?

Amanda Campbell: We have made a great effort over the last couple of years to really listen to what our staff are saying to us. We spend a lot of time—both Rob and I personally but also all of our management teams—with members of staff across the business, talking to them, listening to them, and, importantly, involving them in the decisions that we are making. Previously, not unreasonably, members of staff thought they did not really get the opportunity to engage with the leadership of the organisation. They did not feel that they had the opportunity to contribute to decisions that were being made or changes that were being made, and they did not believe that the leadership of the organisation had a real vision and a strategy for where we were going. I think that has changed and is reflected in the scores.

Rob Behrens: Can I say, Chair, that 90% of our staff now say they understand and support the values and strategy that we have? There are three elements to sustaining this and making it even better. One is strategy. There is widespread support for the new, simple strategy in the organisation.

Second is culture. If we do not practise what we preach in terms of having an open culture in which people can challenge us and have a dialogue with us, people are not going to stay with us. People want to talk to us; they want to have exchanges. That happens on a daily basis.

The third thing is leadership. We cannot be credible if we do not deliver what we promise we will deliver in terms of our operations, in terms of the support that we need to give to our people to improve their professional skills.

This is not something that is magically going to continue. We have to work at it very hard to make sure that the figures are as good as they are this year.

Q117 **Chair:** Your Peer Review Chair, Peter Tyndall, did remark that maintenance of this improvement is not inevitable. What are the risks?

Rob Behrens: Yes. There are huge risks. The risks are that we become complacent. The risks are that we do not continue talking to our people and having exchanges with them when they become critical about what we are doing. A 24% spending cut is still having an impact on the organisation. We will in the next few weeks have to make difficult decisions about what we cut and what we sustain, and that will have to



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be evidence based and we will have to make sure that it is understood and supported in our organisation.

When you have lots of new money, it is easier to make everyone happy with what you are doing, but we are going to have to stop doing things in order to deliver our strategy. That will be difficult for some people who have engaged with that. We have to be absolutely alert to the issue that we are part of a team and that we all have to recognise the contribution that we are making.

One of the most important things for us is the monthly discussion of cases, which we have with the office, in which we do not tell people what to say, but we have a forum in which people can come in and we can discuss the very difficult issues that are being addressed. The idea that the ombudsman has a magic wand of wisdom to be able to say, "This is right" or "This is not right" is simply nonsense. We have to trust in our people, and we have to challenge them appropriately when we think they are not getting it right.

One of the issues that I have noted is that sometimes people have said they are not supported if they make a wrong decision on a complaint, and that a ton of bricks came down on them in the past. That does not happen now. We have tried to do this in a responsible way, giving people feedback, recognising that they have to take risks and make difficult decisions.

Q118 Chair: The peer review team reported what it would call "unanimous praise" for the PHSO's new leadership, the clarity of your strategy, and attributed the improvement in morale to the investment in training for staff, but the staff survey still shows you are well behind on the appreciation of learning and development. Sorry to pick on the worst number, 49%, which is 11% behind the civil service average. How do you explain that disparity, given that you are investing so much in training?

Rob Behrens: I think almost every score improved and you have picked on the one that did not.

Q119 Chair: Yes. I am afraid that is my job.

Amanda Campbell: In fact that one did improve as well, but I accept it is below the civil service average against many that are considerably above it. The learning and development score did improve by 13%, which is quite a significant increase, but it started from a very low base as a reflection of the fact that there was very little learning and development happening in the organisation a couple of years ago. We have put this substantial programme of learning and development in place, but that has largely been for our front-line casework staff. I think there is some recognition in our score that we have not done as much for those outside of the casework area. We are addressing that as well now.

The learning and development block of questions also deals with career progression. One of the things that I know concerns colleagues working



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in the organisation is that we have stripped out a lot of the senior management levels. We have done that purposely to make it a flatter organisation and to save money by reducing the number of senior staff so that we can invest in the front line. People have started to see that potentially there could be fewer career opportunities for them to move up through the organisation.

That is an issue that again we are trying to address by being very clear that the organisation we are designing is one that has career pathways through it. What we are looking to do is recruit people into the more junior roles in the organisation, and then develop them so that they can progress through the various roles that we have in the organisation. They can see real career progression, and that we do not need to go outside first, that we would look within first and help develop people into those promotion roles.

Q120 Chair: Just looking at your staff turnover, it is very high at 40.2%. Your levels of sick absence have also increased. What should we make of this?

Amanda Campbell: Those staff turnover figures were for a point in time, and that was while we were going through the relocation to Manchester and the recruitment of new staff. Throughout that period, which was a collective consultation period, of course, we could not appoint permanent staff members until colleagues in London had had the opportunity to decide whether they wanted to relocate to Manchester. We engaged a lot of temporary staff over that period, so there was a lot of turnover. We are now in a position where the vast majority of staff in our organisation are permanent and the staff turnover rate has dropped dramatically.

On staff sickness, again, there was a point-in-time issue about going through a relocation, a redundancy programme, and lots of change in the organisation. Sick leave peaked back in October 2017, midway through the report year that you are considering. From that month in October 2017, sickness levels have dropped month-on-month through to a much lower rate now and are now well within the CIPD benchmark for good organisations.

Q121 Chair: We can look forward to an improvement. Are those turnover figures for the staff in general reflected among your caseworkers as well, or is there a lower or higher turnover among caseworkers?

Amanda Campbell: The turnover now, again, among our casework staff has reduced significantly. As we have made members of casework staff permanent, a lot of the temporary staff who were working—

Q122 Chair: That was very high as well.

Amanda Campbell: It was because we had a lot of temporary caseworkers, because we could not fill those posts permanently while we were going through the collective consultation. Now the vast majority of



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our casework staff are permanent members and that turnover has reduced.

Q123 Chair: The strength of an organisation depends upon its institutional memory. How are you making sure that you do not lose vital institutional memory after this period of high turnover?

Amanda Campbell: I think Peter Tyndall in his evidence recognised in one of the recommendations from the value for money study that it is about specialist knowledge and retaining memory. We both recognise that, having lost a number of very experience caseworkers from London, that was an issue for us. What we have done is a range of things. We have created a specialist knowledge platform on our IT system, so it is a repository for lots of information about some of the very technical work that we do. We have appointed subject matter experts. Operational managers across the business now specialise in a particular area of expertise, so they are there as points of contact for all members of staff, but also to make sure that all of the information we hold in our knowledge platform is up to date.

Rob mentioned that we hold case discussion forums, open forums, where large numbers of staff come every month to talk about casework with us. We also have quarterly digests, where we focus on particular issues such as mental health, and a monthly digest that goes through all of the information that has been shared in the last month with members of staff. We are layering up the knowledge and systematising it so that we do not ever find ourselves in that position again.

Q124 Dr Rupa Huq: Can I just ask very quickly about the annual report? I think it came out in your answers as well. There is no clear differentiation between what was an enquiry and what was an actual complaint. Can you separate out those two in your next annual report? It is just very confusing for—

Amanda Campbell: As in people who come to us at the beginning to ask questions?

Q125 Dr Rupa Huq: Yes. I think you were saying some people do an initial enquiry, but then others get into a full-blown complaint.

Amanda Campbell: Yes. The terminology—that, again, was something that was highlighted in the value-for-money report—of how we describe what is an investigation, what is an assessment and what is a complaint handled is different across the ombudsman sector. In our annual report we use a figure that is about the numbers of cases that are passed through for further consideration. Of the 114,000 initial inquiries that we had last year, around 32,000 went through for further consideration, so an initial assessment, and then obviously fewer of those at each stage go through to different stages of our process.

Dr Rupa Huq: Yes. It would be clearer for people reading them to know which was which. Thanks.



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Chair: Thank you for that. Thank you very much indeed for very full answers to all our questions. You carry a very heavy burden of responsibility and the organisation still faces huge challenges, but we have to recognise—and we do recognise—how much progress you have made. We hope that that progress will continue and be sustained.

Could you take back to all your staff the thanks and good wishes of this Committee and the support in the changes that are being made? We very much hope that next time you come back you will be able to report to us again further and continuous improvement. Thank you very much indeed.