Written evidence from Dr Minh Alexander and Ms Clare Sardari (PHS 18)

Public Administration and Constitutional Affairs Committee
Parliamentary and Health Service Ombudsman Scrutiny 2019-20 inquiry

We write to submit evidence on a recent experience of the PHSO and policy issues raised by this experience.

PHSO investigated a complaint of a mishandled referral to the Care Quality Commission under Regulation 5 Fit and Proper Person, about an NHS trust director who had been found guilty of proven whistleblower reprisal and breach of the NHS managers code of conduct (an under-declared family interest), who was subsequently convicted of fraud and also criticised for her attempts to resist the proceeds of crime process.

In our view:

- The PHSO process was too protracted

- The Ombudsman himself was unaccountable with regard to a PHSO failure to correct a factual error in its final report, despite this inaccuracy being pointed out prior to publication. He failed for seven months to respond to correspondence which pointed out the pre-publication failure to correct the inaccuracy.

- Concerns raised about this lack of accountability led to the discovery that PHSO has no special procedure for complaints about the Ombudsman himself, causing inherent conflicts in the PHSO's response to any complaints about the Ombudsman himself. This is an astonishing failure by a body which is supposed to be a specialist on complaints handling and it raises underlying issues of culture and organisational hubris.

- There was a lack of rigour by the PHSO in pursuing compliance with its recommendations for corrective action by the CQC, notwithstanding its lack of enforcement powers. It seemed to us that a procedural box had been ticked and thereafter, the PHSO was not interested in enough in ensuring that there was learning or genuine remedy of injustice. The CQC CEO undermined an official apology given as part of the PHSO process, and to our knowledge, PHSO did not challenge this, contrary to its stated aims:

  "We do not have legal powers to enforce our recommendations, but where an organisation is reluctant to implement them, we will try our best to persuade it to do so."

  https://www.ombudsman.org.uk/organisations-we-investigate/putting-things-right

Requests

1. We do not consider that the PHSO model is robust enough to deliver accountability and good governance in public life, because of insufficient powers and the lack of a duty on the PHSO to enforce improvements and corrections. It does not seem good

value for money (budget 2019-20: £25.942 million) and we ask parliament to consider an alternative model of conflict resolution.

2. We ask parliament to ensure that PHSO establishes a specific complaint procedure about complaints about the Ombudsman himself, which introduces an element of independence and external scrutiny. It would be unsafe and unjust to leave complaints about the Ombudsman in his own hands or the hands of his subordinates. In contrast, the Scottish Public Services Ombudsman has a policy for addressing conflicts of interest.

3. We suggest that the PHSO should have a process for handling self-evident factual inaccuracies in its final reports. It should be required to issue post-publication clarification, so that false narratives are not allowed to lie on the record without countervailing facts. The suggested process for acknowledging factual errors in PHSO's final reports should be published and transparent to the public.

Please see in the appendix below the following items:

1. Copy of email by Mandy Campbell which admitted that PHSO has no specific process for responding to complaints about the Ombudsman himself.

2. Copy of relevant section from the Scottish Public Services Ombudsman's complaint policy, about their arrangements for impartiality in the handling complaints about the Ombudsman herself.

3. A more detailed account by Clare Sardari of her experience of the impact of the PHSO process.

APPENDIX

1. Email by Mandy Campbell PHSO Chief Executive about lack of process for complaints about the Ombudsman himself:

[Email redacted for publication]

2. Excerpt from SPSO complaints policy on handling complaints about senior staff and the Ombudsman herself:

"CSCs about senior staff and the Ombudsman

77. CSCs about senior staff (staff on the Leadership Team) can be challenging to handle, as there may be a conflict of interest for the staff investigating the CSC. When serious CSCs are raised against senior staff, it is particularly important that the investigation is conducted by an individual who is independent of the situation. Serious complaints include those types of complaints that pose significant operational, reputational, safety or financial risk to SPSO or its customers. Such CSCs must be immediately escalated to the Head of ISE and depending on the seriousness of the complaint in

their view, to the Ombudsman. We must ensure we have strong governance arrangements in place that set out clear procedures for handling such CSCs.

78. Generally, it will be acceptable for the Ombudsman to investigate a CSC about a member of the Leadership Team where there is a segregation of duties and clearly no conflict of interest. This would include where the investigation officer has had no involvement in the matter complained about. In such instances, the Ombudsman should be consulted on the response to the complaint and make the final decision on the complaint based on the evidence identified by the investigation.
79. In relation to CSCs about the Ombudsman, a judgement needs to be made about whether the complaint relates to specific conduct or action by the Ombudsman or whether it relates to actions taken by the Ombudsman's staff in their name (i.e. about the organisation). Where the complaint specifically relates to the conduct, behaviours or actions by the Ombudsman, the Head of ISE will assess the merits of the case and decide if the complaint should be referred immediately to the ICRS, or considered initially by a member of the Leadership Team. The ICRS will consider complaints about the Ombudsman's conduct, behaviours or actions when referred by SPSO."

    https://minhalexander.files.wordpress.com/2020/10/spso-customer-service-complaints-procedure.pdf

3. Evidence for PACAC Scrutiny Session 2020 with PHSO by Clare Sardari

In 2014 when I raised a concern regarding nepotism at Chief Executive level in South Devon NHS Trust, little did I know that my future – emotionally, economically, socially, mentally, career-wise and in just about every possible way imaginable, would be harmed so dramatically. Little did I know that the processes and structures in place in the NHS and under UK law to 'protect' and care for those who were carrying out their responsibilities and duties as laid down by organisational and national policies, and the law, would be on the whole, useless or corrupt in their own way.

Concerns/complaints are the same thing – they are expressions of discontent or worry and particularly, from my experience, the NHS says one thing and acts in quite a different way when addressing these complaints/concerns. The Department of Health and Social Care has set up regulators - CQC, NHSE, NHSI etc, an Ombudsman and a Freedom To Speak Up service. But, what is now completely apparent, is that none of these bodies have been given the authority or powers to take responsibility for even the most heinous of behaviour within the NHS or Social Care. Either they have fobbed me off with their denials of responsibility or they actually don't have the powers to take action despite supposedly offering supportive services; either way, this situation is completely untenable. With every issue I have raised post winning at ET (if you can call it that!), the response has been 'we don't deal with that' or 'that is not our responsibility'. As a service user of the NHS, I have been thwarted at every stage in my pursuit of justice.

So today the issue of COMPLAINT is the area I'd like to pursue with regards to my contact with the PHSO and their investigation into CQC's regulation and administration of the Fit and Proper Persons Requirement (FPPR).

In 2017, I complained to the PHSO, supported by my then MP and Chair of the Commons Health Select Committee Sarah Wollaston, about CQC's involvement in the recycling of

Paula Vasco Knight to the position of interim Chief Executive at St Georges Hospital in London.

After investigation the PHSO found that CQC's handling of FPPR was not transparent, fair or proportionate and this amounted to maladministration. *(a link to the 'Blowing the whistle: an investigation into the Care Quality Commission's regulation of the Fit and Proper Persons Requirement')*

Subsequently, the PHSO recommended that CQC, within 8 weeks of the report should:

a. *apologise for the injustice (loss of opportunity, frustration and distress) their actions have caused me*
b. *offer me £500 in recognition of the injustice caused;*
c. *review their learning from this case and report back about improvements they have made to demonstrate rigour in their FPPR considerations in future.*

Below, I have cut and paste the 'apology' letter I received from Professor Edward Baker – Chief Inspector of Hospitals. I was most disappointed and distressed by the tokenistic and very grudging apology he gave me on behalf of the CQC. It was the height of condescension and certainly did not reassure me that the CQC meant to learn anything from this process. I am in complete agreement with the Ombudsman's Principles of Good Administration but cannot identify the part in Professor Baker's letter which adheres to the general principle of *'Putting things right…'* What he does successfully is he puts the words in the right order but there is no sincerity, thus he is not putting things right! He is doing the bare minimum that has been asked of him and he makes that very clear.

[Email redacted for publication]

This apology coincided with a press release from Ian Trenholm CQC CEO

"We recognise that the handling of this case – both by CQC and by wider NHS organisations – did not meet Ms Sardari's expectations of how the Fit Proper Persons Requirement (FPPR) should operate, and acknowledge her frustration and distress. We take the treatment of whistleblowers very seriously and are wholly committed to the Speak Up agenda.

"This was a challenging case which clearly demonstrates the difficulties faced by NHS bodies who are required to operate the FPPR system and for CQC operating under the current regulatory framework. The current framework needs reform if it is to meet the needs of people, providers and regulators.

"Those difficulties have been acknowledged for some time and they are the subject of an independent Review by Tom Kark QC, who is due to report to the Department of Health and Social Care shortly.

"We do have concerns about the approach adopted by the Parliamentary and Health Service Ombudsman (PHSO) which led to some of the findings of maladministration. There was a considerable amount of contradictory evidence for the Trust to assess. This included an Employment Tribunal decision, which was not consistent with other pieces of evidence. Under existing FPPR regulation our role is to consider whether the Trust acted reasonably in coming to their conclusions about the weight that should be attached to various pieces of

evidence, rather than whether we would have reached the same conclusions. We judged the Trust had performed its obligations reasonably when faced with this difficult situation. We are disappointed that the PHSO came to a different conclusion. We have made these concerns clear in our response to the report."

As a result of the 'apology' letter and Ian Trenholm's press release I decided to complain to Peter Wyman - Chairman CQC– see below:

[Email redacted for publication]

Please find below a copy of the reply I received from Peter Wyman:

[Letter redacted for publication]

The third and final recommendation the PHSO report made was that the CQC would:

Review their learning from this case and report back about improvements they have made to demonstrate rigour in their FPPR considerations in future.

From this statement, I was under the impression that I would receive details of CQC's learning and improvements. Apparently, this information is not generally provided as a matter of course to the complainant. I find this obscure as the main reason for complaining is to bring about change. I also need to see the evidence that the changes have actually occurred or will be made.

I did receive this from PHSO when I asked for evidence of compliance:

[Email redacted for publication]

I am regularly advised that as a whistleblower my views, information, concerns, experiences etc are valued and respected (see communications above) but still the disrespect, and disregard continues and remains a consistent part in the way that power responds to me – a much harmed whistleblower that the system purports to want to protect!

I now return to the general heading of this evidence relating to the PHSO's investigation into CQC's administration of FPPR - COMPLAINT

As you will see throughout, there is no one taking responsibility for ensuring that action takes place for change. Everyone is telling everyone what they should be doing but no-one is ensuring it is done because none of the regulators are being held to account to provide evidence.

PHSO 'recommended' that CQC apologise to me. As I mentioned above, the word 'sorry' was used but not in a way that anyone could possibly believe was genuinely meant. The context, and the giving with one hand and the taking away with the other resulted in more frustration on my part and further raising of concerns or complaints.

The specific evidence of meaningful change and improvements were not shared and although I understand that confidentiality should be maintained, why can I not know the name and contact details of a legal adviser? Where does transparency figure in all of this? To me, this

smacks of secretive behaviour, of fear of retribution or discovery instead of openness and transparency. Transparency is about seeing things clearly, the first step towards inspecting and adapting, or changing things for the better!

The financial remedy is tokenistic, I accepted it as my current income is limited and every little helps, but does it really compensate for the emotional and mental damage of the harm caused by the recycling and subsequent validation of Paula Vasco Knight? It does, however affect my own perception of my value to society - £500!

Where does my pain end? Is it when I have been brow beaten into defeat by the NHS because I dared to raise a concern/complaint against one of their rising stars?

So at the end of the day do I think that the stress of the PHSO investigation and the outcomes as a result, represent good value for money, and good value for the personal stress involved in the process and the added stress at the end? No, I don't. The only way change will happen is when those who can hold others to account on their behaviour have the power to do so, until then the status quo remains. Effective complaint handling could make all the difference, but it must go hand in hand with the power to take action and create change. Additionally, new legislation which properly protects whistleblowers from detriment from the moment a concern or issue is raised, is probably the only way forward for a more equal, open and transparent NHS and society!

October 2020