

## Written evidence from Nicholas Wheatley (PHS 25)

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

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#### 1. **The Complainants' Voice – An Independent Report Commissioned by the PHSO**

The complainant's voice is very rarely heard by the committee and as a consequence only one side of complaint handling by the PHSO is heard at the annual scrutiny meetings.

In March 2020 Opinion Research Services published a report into impartiality and Charter Commitment 10, commissioned by the Ombudsman.

The resulting 7 page report provides insight into many of the problems experienced by complainants when they take complaints to the PHSO. Committee members interested in the complainant experience should read this independent report to gain a clearer idea of some of the problems still experienced by those who use the services of the PHSO.

[https://www.ombudsman.org.uk/sites/default/files/ORS\\_Summary\\_Report\\_on\\_Impartiality\\_March\\_2020.pdf](https://www.ombudsman.org.uk/sites/default/files/ORS_Summary_Report_on_Impartiality_March_2020.pdf)

#### 2. **The Complainants' Voice – Contrasting Stories**

Also in March 2020 the Ombudsman released his Casework Report consisting of 30 reports into the handling of complaints made to the PHSO and their subsequent

outcomes. The Ombudsman described the Casework Report on the PHSO website as follows:

*“The Report offers valuable lessons about the importance of good complaint handling...”*

<https://www.ombudsman.org.uk/publications/ombudsmans-casework-report-2019-0>

The Casework Report can be found here:

[https://www.ombudsman.org.uk/sites/default/files/Ombudsman\\_Casework\\_Report\\_2019.pdf](https://www.ombudsman.org.uk/sites/default/files/Ombudsman_Casework_Report_2019.pdf)

The first complaint report on page 12 of the Casework Report describes a complaint about the Child Support Agency, how it was investigated and how the PHSO went about “putting it right”.

However, the complainant in question, who was not given the opportunity to give her side of the story, has a very different version of events from that presented in the Casework Report. She states regarding the PHSO investigation that:

*“I’m very relieved to say that, after approximately four and a half years, it has finally been resolved in my favour, but only after an almighty battle and the involvement of solicitors on both sides. I am acutely aware that, had I not involved solicitors to threaten a judicial review application, my complaint would not have been successful, despite being completely justified. Whereas the PHSO is supposed to provide a relatively pain-free alternative to litigation, I have spent thousands of hours fighting my corner and am in no doubt that the time lost has taken its toll on me, my children and wider family.”*

The full story can be found here:

<https://phsothetruestory.com/2020/05/17/rob-behrens-the-rumpelstiltskin-of-his-day/>

Other complainant’s stories can be found in the book “What’s the Point of the Ombudsman?”

### **3. IT System Teething Problems**

In the letter of 18 May 2020 from the Chair of PACAC to the Ombudsman, question 2 asks:

*“...you...invested £353,000 in new ICT capabilities and technical infrastructure...Were there any teething issues with this new ICT provision?”*

<https://committees.parliament.uk/publications/1119/documents/9639/default/>

In his reply of 5 June 2020 the Ombudsman states:

*“As with any project of this nature, the ICT team...were on hand...to work through any post go-live issues. These were addressed quickly and effectively”*

<https://committees.parliament.uk/publications/1467/documents/13497/default/>

But on page 41 of the 2019/20 PHSO Annual Report it states:

*“Difficulties in extracting data from our new CMS meant that fewer people could be surveyed in the final two quarters of the year and this will have affected the reliability of the scores.”*

It seems that for two whole quarters, maybe more, the PHSO were unable to extract data from their new CMS, and so unable to carry out their surveys for the Service Charter and probably complainant satisfaction surveys as well (see section 4 below). This is quite a major teething problem. Has it been rectified yet?

#### **4. Complainant Satisfaction Rates Missing**

The Annual Report usually contains information about complainant satisfaction with the PHSO service. It is missing for the 2019/20 Annual Report.

#### **5. Missing Quarterly Publications**

a) The PHSO has not published a quarterly report on NHS Complaints since Quarter 1 of 2019/20.

b) The PHSO has not published a quarterly Service Charter Report since Quarter 2 of 2019/20.

#### **6. Charter Commitment 11 Has Fallen From 59% to 47%**

Charter Commitment 11 is described as:

*“We will explain our decision and recommendations, and how we reached them”*

The score for this Charter Commitment has fallen from 59% in 2016-17, when the current Ombudsman began his tenure, to 47% in 2019/20.

#### **7. Charter Commitment 10 – Misleading Interpretation of Report**

Charter Commitment 10 is described as:

*“We will evaluate the information we’ve gathered and make an impartial decision on your complaint”*

As previously explained in section 1, the Ombudsman commissioned a report by Opinion Research Services into Charter Commitment 10 and how to measure impartiality as perceived by complainants. On the PHSO website it states that:

*“Overall, our research company concluded that PHSO should combine the feedback we already receive from complainants and organisations on a number of key charter commitments that directly relate to fairness. This combined total provides a well-rounded score on whether PHSO has demonstrated it has acted fairly.”*

<https://www.ombudsman.org.uk/about-us/corporate-information/how-we-are-performing/performance-against-our-service-charter/research-fairness-and-impartiality>

However, this misrepresents the conclusions of the report which were:

*“In this context though, it is probably worth considering what, for participants, are the key components of impartiality on the part of PHSO. It can be assumed from the findings that these are:*

- *Being fair and thorough by looking at both side of complaints carefully;*
- *Gathering all relevant data and using it for cases;*
- *Treating complainants with compassion, empathy and understanding;*
- *Having good communications, especially keeping in touch and providing updates*
- *Listening to key issues and understanding them;*
- *Giving the option to ask questions and have those questions answered;*
- *Being transparent about how decisions are reached;*
- *Not rushing the closure of a case; and*
- *Taking account of complainant vulnerabilities and making reasonable adjustments.*

*It is thus possible that a rounded, balanced assessment of impartiality might be secured by assessing perceptions of how PHSO performed in these areas.”*

[https://www.ombudsman.org.uk/sites/default/files/ORS\\_Summary\\_Report\\_on\\_Impartiality\\_March\\_2020.pdf](https://www.ombudsman.org.uk/sites/default/files/ORS_Summary_Report_on_Impartiality_March_2020.pdf)

It can clearly be seen that the report conclusion does not state that:

*“PHSO should combine the feedback we already receive....on a number of key charter commitments that directly relate to fairness”*

Nor does it state that:

*“This combined total provides a well-rounded score on whether PHSO has demonstrated it has acted fairly.”*

The PHSO is being deliberately misleading in order to promote a Charter Commitment 10 score that is acceptable to the PHSO but is not a meaningful measurement of perceived impartiality.

## **8. Charter Commitment 10 - Unacceptable Measurement of Impartiality**

The PHSO intend to create a score for Charter Commitment 10 by combining a number of other Charter Commitment scores.

*“Going forward, we will combine the scores on the following commitments:*

- 5. We will listen to you to make sure we understand your complaint*
- 8. We will gather all the information we need, including from you and the organisation you have complained about before we make our decision*
- 9. We will share facts with you, and discuss with you what we are seeing*
- 11. We will explain our decision and recommendations and how we reached them.*

*This will provide an overall score on whether our users feel we are making fair and impartial decisions and will be included in our regular quarterly reporting on our Service Charter.”*

<https://www.ombudsman.org.uk/about-us/corporate-information/how-we-are-performing/performance-against-our-service-charter/research-fairness-and-impartiality>

It should be clear from a moment’s thought that a complainant might decide that the PHSO has:

- Understood the complaint (Commitment 5)
- Gathered all the information (Commitment 8)
- Shared and discussed the facts (Commitment 9)
- Explained the decision (Commitment 11)

...and yet still produced a biased and partial decision! Clearly the new, cobbled together, version of Charter Commitment 10 fails to measure whether a decision has been made impartially.

It is also surely not acceptable to collect feedback from complainants that will be used to assess a score for impartiality without informing the complainants that is what they are collecting the information for.

## **9. Clinical Advice Review Independent Adviser Recommendations Watered Down**

Sir Liam Donaldson, The Independent Adviser to the Clinical Advice Review, produced an excellent report that got to the heart of many of the problems faced by complainants when they bring complaints to the PHSO. It was strongly felt that if his recommendations were fully implemented it would transform the way complaints are handled by the PHSO and create a much more positive and healthy relationship

between complainants and the PHSO. There was a feeling of optimism that at last a positive breakthrough had been achieved.

Unfortunately the recommendations have been watered down to such an extent that they will not lead to the transformative change that was hoped for.

For example, two of the recommendations that would have the most positive effect in the handling of complaints have not been implemented. These are:

*“1. a) At the outset, clinical advisers should jointly, with the caseworker, create an understanding of the care “in the round”, identify the clinical information to be requested and assembled, and relate this to the heads of complaint”*

and

*“2. The complainant should be asked to comment on the request for clinical advice and the questions posed”*

Neither of these recommendations have been adopted.

## **10. Peer Review - A Conflict of Interest**

In the transcript of the scrutiny meeting of the PHSO on 18 May 2020 the Ombudsman states in Q46

*“...the International Ombudsman Institute will validate membership of peer reviews to make sure they retain the necessary independence.”*

It must be obvious to committee members that there is a conflict of interest in allowing members of an unaccountable supranational organisation (The International Ombudsman Institute) to be the only reviewers of Ombudsman’s work.

For example the recent peer review of the Ombudsman of Barcelona was carried out by the PHSO Ombudsman and the Belgian Ombudsman.

[https://www.ombudsman.org.uk/sites/default/files/2020-06/Peer%20review\\_SGC\\_Abril\\_2020.pdf](https://www.ombudsman.org.uk/sites/default/files/2020-06/Peer%20review_SGC_Abril_2020.pdf)

The possibility of a “you scratch my back....” approach cannot be ignored as the Ombuds in question may expect to be reviewed themselves at some time in the future.

It cannot have escaped the notice of the committee that the President of the International Ombudsman Institute is Peter Tyndall, a close colleague of Rob Behrens and one of the members of the panel which carried out the peer review of the PHSO in 2018.

A peer review does have some value of course but it is not a replacement for fully independent scrutiny and would never have public confidence as the only measure of value of the Ombudsman’s work. The conflict of interest is too apparent.

## **11. “The Accountability and Scrutiny of the Ombudsman is very limited”**

It is clear from the Clinical Advice Review and the Peer Review and the Review of the Handling of Nic Hart’s Case that the Ombudsman has antipathy towards independent scrutiny.

The Peer Review was carried out by fellow Ombuds and a former staff member of the Scottish Ombudsman.

The Review of the Handling of Nic Hart’s Case was carried out by a current member of PHSO staff

The only recent example of truly independent scrutiny has been the report by Sir Liam Donaldson as part of the Clinical Advice Review. Unfortunately the recommendations of this excellent report have been watered down and will not provide the transformative change required at the PHSO (see section 9 above).

In a recent case (EA/2019/0189) heard by the First-Tier Tribunal, Judge Buckley stated:

*“The accountability and scrutiny of the Ombudsman is very limited”*

## **12. Conclusion**

The evidence in this submission and others points to an Ombudsman who is able to operate with impunity in a way that is not conducive to the public good as a consequence of limited scrutiny and accountability. Only parliament can ensure that the public’s right to fair and just treatment is respected and upheld by putting in place a more rigorous system of accountability. The claim that the Ombudsman must be independent of parliament does not hold water when that independence leads to poor service for the public.

*October 2020*