Written evidence from Joy Hibbins (PHO 20)

Public Administration and Constitutional Affairs Committee
Parliamentary and Health Service Ombudsman Scrutiny 2020-21 inquiry

I am a former patient who experienced notifiable safety incidents under an NHS Trust.

My complaint about the NHS Trust was fully upheld by the Parliamentary and Health Service Ombudsman (PHSO). The PHSO identified that "failings" had occurred, and they made recommendations to the NHS Trust to prevent similar incidents happening again.

The NHS Trust agreed to follow the recommendations of the PHSO. However, three months later, similar incidents happened again in the same NHS Trust. These subsequent incidents were designated as notifiable safety incidents by the NHS Trust. The incidents caused "highly significant harm" to me, according to an independent report commissioned by the NHS Trust.

On the PHSO website, it states:

"If we find an organisation has got things wrong, we can ask it to show how it will prevent this happening again. This is so other people don't go through the same thing."

Unfortunately, on this occasion, the PHSO did not achieve its aim of preventing people from experiencing similar incidents.

It meant that the PHSO upholding my complaint was ultimately meaningless to me, because similar incidents happened again so quickly after its findings and recommendations, and these similar incidents caused such significant harm to me.

The following is an account of what happened when the PHSO upheld my complaint.

As part of their investigation into my complaint, the PHSO had found evidence that the original incidents may indicate "systemic problems" within the NHS Trust, and it recommended that the Trust take steps to prevent further incidents occurring in future. The PHSO recommended that the Trust consider making changes to its policies.

The PHSO also advised the NHS Trust to inform the Care Quality Commission (CQC) of what had occurred, and asked the NHS Trust to advise the CQC of what they intended to do, to prevent similar incidents from happening again.

The Trust made changes to its policy documents, as the PHSO had recommended. But just over three months later, similar incidents occurred again. These incidents were designated as notifiable safety incidents by the NHS Trust. The NHS Trust carried out a Serious Incident Investigation.

The NHS Trust informed me that they would need to arrange an independent psychological assessment to quantify the level of harm caused to me by the notifiable safety incidents. I underwent a psychological assessment with the independent psychologist who the NHS Trust selected. Their independent psychologist's report concluded that the repeat incidents had

caused me “highly significant” psychological harm. The psychologist’s report stated that the incidents were “highly damaging”.

I contacted the PHSO and informed them that similar incidents had occurred again, and that these “repeat” incidents had been assessed as having caused highly significant harm.

I also wrote individually to Rob Behrens to inform him of what had happened. He informed me that the PHSO would reply to me.

It appeared that all the PHSO could do was to ask the NHS Trust to inform the Care Quality Commission that similar incidents had happened again.

The PHSO told me that the NHS Trust had complied with the PHSO’s recommendations by amending their policy documents. Technically, that was “complying”.

The PHSO cited the “limits of their powers” and that there was nothing more they could do.

But the NHS Trust amending their policies had not prevented similar harmful incidents happening to me very shortly afterwards.

Perhaps one of the issues is that the PHSO simply recommending that an NHS Trust makes amendments to its policy documents may not be enough, and perhaps the PHSO needs to ask the NHS Trust how in practice they will ensure repeat incidents do not happen. It may need to be about how the NHS Trust ensures that all their staff take learning from what happened – it may be that the “learning taken” needs to be embedded in staff training, for example.

I was extremely disappointed with how the PHSO responded to the repeat incidents which happened so soon after their recommendations to the NHS Trust – particularly in view of the significant harm that these repeat incidents caused.

My impression was that the PHSO did not given enough consideration to what changes may need to be made in PHSO processes to ensure that this did not happen again – i.e. a consideration of whether the PHSO may need to do more, in the future, than to focus on recommendations about changes to *policy documents* within an NHS Trust.

Changing policy documents, on the recommendation of the PHSO, may not in itself demonstrate a commitment to change, on the part of the NHS Trust. I think the PHSO may need to ask for more in future, in order that an NHS Trust demonstrates to the PHSO that it is genuinely and pro-actively going to commit to taking steps to prevent similar incidents from occurring again.

In retrospect, the fact that the NHS Trust leadership had resisted acknowledging any failings or shortcomings in their processes, or in staff conduct, right up until the day that the PHSO issued its final report, should perhaps have signalled to the PHSO that the NHS Trust might be less rigorous in following up on any recommendations, other than on a more superficial level.

After the PHSO delivered its *draft* report to the NHS Trust, the Trust leadership had continued to make representations to the PHSO to try to demonstrate that there had been no failings or shortcomings, in relation to the "systemic problems" which the PHSO had identified. The NHS Trust leadership was not prepared to accept the PHSO findings in the draft report which related to the systemic issues, nor were they prepared to accept that there were systemic issues. The NHS Trust leadership continued with this resistant standpoint, making further representations on the day before the PHSO issued its final report.

I think perhaps this "tenacious resistance to the findings" should have been noted in the PHSO's final report, and perhaps recommendations should have been made by the PHSO, in the light of this resistance.

On the day that the PHSO delivered their final report, the NHS Trust then accepted all the findings and apologised, and followed the recommendations to change their policies. This sudden "volte-face" happened because an official body had ruled on the matter.

In retrospect, perhaps the PHSO could also have focused more on another aspect of the PHSO report, and what that might indicate in terms of how the NHS Trust might respond subsequently. In its final report, the PHSO commented on how one particular incident had caused me "great and unnecessary distress". The PHSO report further concluded that there had been no evidence that the NHS Trust leadership had shown regret for this action. The PHSO wrote in its final report: "We find no evidence of regret or apology for this".

There was significant evidence of the NHS Trust's resistance to acknowledging and learning from errors or failings, which was available to the PHSO.

Ultimately, I wondered what the point of going through the PHSO process was. The PHSO had upheld my complaint but this had not prevented similar incidents and similar harm from happening to me (or to other patients) again. The PHSO upholding my complaint seemed meaningless.

My impression (in terms of the Care Quality Commission) was that they contacted the NHS Trust, and the NHS Trust gave them various reassurances, and they were satisfied with that.

It has felt that the wider system, which includes the PHSO and the Care Quality Commission, is failing to protect patients from repeated harm.

October 2021