Written evidence L. Lane (PHO28)

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

Dear members of the PACAC committee,

I am writing in response to your call for evidence on the time taken for the PHSO to respond to correspondence and my complaint to the PHSO case reference C2099380 and complaint review request R-01433 and R-01587, during 2020 and 2021. I hope that out of 11 committee members, there are some, or all of you, that by reading this evidence will see the injustice and pointlessness of the PHSO service to the public, and that you will strongly seek and support positive changes. To Rachel Hopkins MP: this evidence will help answer how and why Luton has the lowest NHS CHC funding in the country of only 12 cases per 50,000 of population.

The PHSO mediation response and investigation process is clearly not meeting its obligation to the public. PACAC's annual scrutiny into the work of the PHSO serves little use. The PHSO should be audited by an independent body (outside of parliament) to perform quality standard checks on responses to complainants. This would identify the very poor standard of responses to the public, with careless errors, such as dates after the patient's death, a reluctance to respond to complaint points, and evasive letters that are full of obfuscation. Such obfuscation that makes many members of the public unable to follow up with their complaint. From my experience of using the PHSO service, I have found their main goal is to avoid communication and end the complaint process.

In my opinion, the PHSO is 'unaccountable' and 'untouchable' and they appear to know it. Therefore, the PHSO caseworkers are not, and do not need to be diligent, accurate or thorough in their responses to complainants, or even uphold any complaints at all, because the PHSO default is simple, if you wish to challenge the decision the only route is by judicial review through the courts. Few members of the public can afford to do this, as well as the fact that the cost is likely to outweigh the gain.

The PHSO is very far from its vision to provide an exemplary ombudsman service which is fair and impartial. I have used the Ombudsman service in the private sector, and it was an exemplary experience and how an Ombudsman should conduct an investigation as a final arbitrator using integrity and diligence, a sharp contrast in every respect to the injustice and disgraceful experience I received with the service of my complaint to the PHSO.

Background

My complaint to the PHSO referred to NHS England's, Independent Review Panel report and how this report had factual and clerical errors that allowed the NHS IRP decision process to unfairly deny the awarding of CHC funding to my mother. My mother had been awarded a 'severe' weighting in the cognitive domain, and under the rules would automatically receive CHC funding if she received a second 'severe' weighting, but factual errors created specific faults in the NHS IRP decision process that allowed the behaviour domain to be unfairly downgraded from a 'severe weighting to a 'high' weighting. I was expecting the PHSO to uphold my complaint in light of these specific faults, or at the very least recommend a fresh IRP. Instead the PHSO made excuses for these faults and dismissed them.

THE TRAIL OF CORRESPONDENCE OF MY COMPLAINT

28 August 2019 my complaint about NHS IRP decision was sent to the PHSO.

21 February 2020 I received the PHSO letter not to take my complaint further.
The PHSO noted the NHS IRP report had a factual error of weight gain instead of weight loss, but she excused and dismissed this specific fault, stating it did not impact on the NHS IRP's overall decision.

5 March 2020 On my request he PHSO caseworker agreed to a telephone call to take place on 12 March 2020. I sent an email on 11 March 2020 so that she had sight of my points of complaint before the telephone call.

12 March 2020 The PHSO caseworker called my husband and myself, as agreed. On discussing our first complaint point, **she said 'well I can see you are not going to agree with me, so there is no point continuing this conversation and I am going to end this call now and I will send you a letter and you need to complete a complaint review form'.** We were both very shocked by this response, we tried to move to our next points, but she was adamant to end the call, so she achieved her objective to close down our complaint discussion. She never sent us a letter or complaint form and I sent her many follow up emails in the coming weeks. I then sent an email to her manager, and I received an email from the original caseworker apologising she had not sent a complaint form and that she had gone on leave and asked her colleague to do this, but evidently this did not happen. So it had taken much effort and time before I was even in receipt of a complaint review form.

I returned the complaint form on 29 June 2020.

20 August 2020 I received an email response from PHSO, Operations Manager. This email did not address most of my complaint points. **In her email she apologised for an incorrect date in their decision letter which was a year after my mother's death. She also acknowledged there was a clerical error in the NHS IRP report, in which another patient's name appeared. This error, stated, 'care needs were met using planned interventions and were routine' for another patient name. This factual error was excused and dismissed, by stating my mother's name was correct in other places.**

My response email to the PHSO, Operations Manager 2 September 2020, again repeated my complaint points that she had not yet responded to.

On 16 September 2020 the PHSO, Operations Manager responded in a short email. In one sentence, she erroneously stated 'you raise concerns around weight loss recording and weighting of the cognitive domain. **I raised no such concern over the cognitive domain as my mother had already been awarded a 'severe' weighting for this domain.** She also stated 'It is not required that I comment specifically on each of these elements in a review decision letter. We have reached the end of our process. So again, my complaint points were unanswered.

I sent a letter to Mr Behrens on 29 September 2020 expressing my dissatisfaction with the PHSO process. I received an email receipt notification.

On 2 October 2020 my MP wrote to the PHSO, Mr Behrens, to ask for a response to my complaint points that had so far been overlooked and not responded to.

20 November 2020 A PHSO senior case worker responded to my MP and stated in an email that he would try to reply by 19 December 2020, but it would be more realistic to expect a response early in the New Year. Bizarrely, I note he also created a new reference number for this case R-01587. He responded to my MP on 11 December 2020. I was not copied into this response, and I did not receive a copy until 20 March 2021 when I chased up my MP to see if he knew what was happening. My MP stated it is the normal process for the PHSO to reply to the complainant and copy in the MP.

1 April 2021 I replied to Mr Behrens in response to the PHSO senior caseworker's letter of 11 December 2020, thinking he had replied on Mr Behrens behalf. I received no response or acknowledgement of my email.
28 April 2021 I emailed the senior caseworker directly.
5 May 2021 PHSO, Head of Review and Feedback Team replied on behalf of Mr Behrens. She also acknowledged that I had emailed the senior caseworker. She confirmed the senior caseworker would not be responding. She passed on his apologies for the incorrect Psychiatrist date he mentioned in his letter, which was a year after my mother's death. She also apologised that I received no acknowledgement receipt to my original email to Mr Behrens.
12 May 2021 I responded to PHSO, Head of review and feedback team. I requested that with all the evidence of errors in the PHSO letters and the NHS IRP report, the fairest solution to my complaint would be for a fresh IRP to be carried out by an impartial region, say the North West.

13 May 2021 I received an automatic email response that my email was being considered and I would receive a response in 10 days.

28 May 2021 I sent a follow up email as I did not receive a response after 15 days.
28 May 2021 PHSO feedback team apologised for not responding. The Head of Review and Feedback Team was absent, and she was now on annual leave until 7 June 2021.
8 June 2021 email from PHSO, Head of Review and Feedback team apologising for the long delay in responding. She stated they will not be asking the NHS to convene a fresh IRP and are closing the case and that judicial review in the courts was the only option left to me.

THIS IS WHY I HAVE NO FAITH, TRUST OR CONFIDENCE IN THE PHSO TO ACT FAIRLY AND IMPARTIALLY WHEN INVESTIGATING COMPLAINTS.

In the PHSO's letter of 21 February 2020 it states, 'we can only uphold a complaint about an eligibility decision if there is some specific fault in the way the IRP reached the decision'.

There were 3 specific faults (detailed below) in the NHS IRP report, that affected their decision process. The PHSO accepted these errors in their correspondence, so why did they not uphold my complaint as they said they would. **On this basis, if any specific faults in the NHS IRP report that affect the decision process are highlighted to the PHSO, and are then simply excused and dismissed by the PHSO, then the public will never ever receive any justice from the PHSO service and the PHSO service is a waste of time and taxpayers funding.**

I requested a fresh IRP to be convened, as the fairest solution to my case, but this was denied by the Head of the Review and Feedback Team.

1. **WEIGHT GAIN INSTEAD OF WEIGHT LOSS.**

The PHSO's letter of 21 February 2020 accepted a factual error within the IRP report of weight gain instead of weight loss, but then the PHSO excused the factual error by stating my mother had weight gain after the claim period. However, the PHSO does not mention that my mother also had weight loss too. During the review period my mother commenced antipsychotic medication, which has a temporary common side effect of weight gain, after this initial period she reverted to weight loss again. During the claim period this factual error was used in the NHS IRP decision process, so my complaint should have been upheld.

2. **ANOTHER LADIES NAME APPEARING IN THE NHS IRP REPORT**

The PHSO's letter of 20 August 2020 accepts and confirms a clerical error in the NHS IRP report of another lady's name appearing in a statement, saying 'care needs were met using planned interventions '. The PHSO then dismissed this factual error stating the rest of the report refers to my mother and that my mother did not need one to one care. This incorrect name was a factual error. During the claim period this factual error was used in the NHS IRP decision process and therefore my complaint should have been upheld.

3. **DAILY ANTIPSYCHOTIC INCORRECTLY DESCRIBED AS PRN (as and when required) AND ONLY NEEDED TWICE IN THE REVIEW PERIOD**

The PHSO's letter of 11 December 2020 accepts that in the NHS IRP report point 9.5 the IRP incorrectly indicates that Risperidone was given on a PRN (as required basis) and this was given twice in the review period. The PHSO then excuses this factual error by stating elsewhere in the IRP report (8.7, 8.18) the dosage is correctly noted.
The PHSO is incorrect, in IRP point 8.18 states 'the panel note that Risperidone PRN was prescribed for a short period.' During the claim period this factual error was used in the NHS IRP decision process and therefore my complaint should have been upheld.

3.1 'SEVERE' BEHAVIOUR DESCRIPTOR

NICE GUIDELINES STATE THAT RISPERIDONE SHOULD ONLY BE PRESCRIBED, AS A LAST RESORT, FOR DEMENTIA PATIENTS WHO ARE AT RISK OF HARMING THEMSELVES OR OTHERS OR SEVERELY DISTRESSED.
NICE guidelines are evidence based recommendations for health and care in England and cover the NHS in England and NHS organisations, such as clinical commissioning groups. The PHSO's letter of 11 December 2020 stated that NICE guidance does not directly translate to the weighting for CHC funding.

The PHSO's letter of 11 December 2020 the PHSO states "Mrs Lane is correct, the IRP did indeed accept that her mother required a 'prompt and skilled response' to her behaviour. The phrase 'prompt and skilled behaviour' is included in the descriptor for a 'severe' need. However, that is not what the full descriptor says:"

*Challenging behaviour of severity and/or frequency that poses a significant risk to self, others or property.
*The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that **might** be outside the range of planned interventions."*

The PHSO then states:- Importantly, the IRP did not consider the level of response needed for my mother was 'outside the range of planned interventions'. The descriptor for a 'high' level of need as set out in the IRP and in PHSO's decision letter says:-

*Challenging behaviour of type and/or frequency that poses a predictable risk to self, others or property.
The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.

*The PHSO letter has omitted the first sentence of the full descriptors, which I have inserted.

The PHSO's letter in February 2020 acknowledges my mother's escapes from the care home and that the IRP noted significant behavioural problems. During the 6 week review period there were 2 'urgent' call outs to the Psychiatrist to prescribe antipsychotic medication, and 4 escapes from the care home requiring immediate responses to locate and return her, which can only be deemed as outside the range of planned interventions. The PHSO report states 'there were lots of times where she hit staff and shouted at residents' including trying to strangle a carer. The PHSO accepted that the IRP had identified my mother's behaviour as requiring a 'prompt and skilled response' (for which the 'high' descriptor carries no such wording). Given the above facts and urgent need of antipsychotic medication, for the seriousness of her aggression. It is hard to understand why the PHSO, (together with the specific faults that distorted the decision process) did not easily conclude that my mother met the 'severe' descriptor for behaviour.

After enduring 3 years of the NHS CHC process, and over a year of the PHSO complaint process, and at the same time dealing with my mother's illness and death, it is clearly inhumane to put people through such bureaucratic processes There must be a fairer, unbiased, impartial, accurate, efficient, kinder, money saving and time saving solution that can be found, such as a short 'tribunal court process'.

October 2021