House of Commons

Public Administration and Constitutional Affairs Committee

PHSO Annual Scrutiny 2016–17: Government and PHSO Response to the Committee's Third Report

Sixth Special Report of Session 2017–19

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Public Administration and Constitutional Affairs

The Public Administration and Constitutional Affairs Committee is appointed by the House of Commons to examine the reports of the Parliamentary Commissioner for Administration and the Health Service Commissioner for England, which are laid before this House, and matters in connection therewith; to consider matters relating to the quality and standards of administration provided by civil service departments, and other matters relating to the civil service; and to consider constitutional affairs.

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Committee reports are published on the Committee's website at www.parliament.uk/pacac and in print by Order of the House.

Evidence relating to this report is published on the inquiry publications page of the Committee's website.

Committee staff

The current staff of the Committee are Libby Kurien (Clerk), Sarah Thatcher (Clerk), Ian Bradshaw (Second Clerk), Dr Patrick Thomas (Committee Specialist), Dr Philip Larkin (Committee Specialist), Makka Habre (Committee Specialist), Dr Henry Midgley (Committee Specialist), Gabrielle Hill (Senior Committee Assistant), Iwona Hankin (Committee Assistant), and Mr Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Public Administration and Constitutional Affairs Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 3268; the Committee's email address is pacac@parliament.uk.

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1. The Public Administration and Constitutional Affairs Committee published its Third Report of Session 2017–19, *PHSO Annual Scrutiny 2016–17*, as HC 492 on 24 April 2018. The Government's response was received on 19 July 2018 and is appended to this report as Appendix 1. The Parliamentary and Health Service Ombudsman (PHSO) also provided a response, on 18 July 2018, and this is appended to this report as Appendix 2.

Appendix 1: Government Response

Further to the publication of the report of the Public Administration and Constitutional Affairs Committee, *PHSO Annual Scrutiny 2016–17*, on 24 April 2018, we are pleased to provide a response to those recommendations and conclusions that fall to the Cabinet Office and the Department for Health and Social Care.

We welcome the report, and commend the Committee on its valued, continued contribution to the debate on historic cases and how to improve the manner in which complaints about government departments and the NHS in England are handled. In particular, improving the way in which the NHS manages, investigates and responds to complaints and wider feedback will be critical in shaping a culture that listens to, and learns from, patients and service users, and ends a culture of defensiveness.

It is therefore important that these organisations view and manage complaints and wider feedback in a positive manner, and use the information obtained to improve service delivery.

Historic complaints:

We agree that the PHSO is not the correct body to carry out inquiries into historic cases However, there remains a need for them to be addressed, both in the interests of the families involved and in ensuring that any safety lessons that can still be learnt are. We therefore endorse and repeat our predecessor Committee's recommendation; that the Department of Health and Social Care should develop a proportionate, time limited, mechanism to independently investigate and address those cases were legitimate questions or grievances remain. There is also a need to address local complaint handling and investigations in the NHS to ensure that there are fewer failed investigations in the future, we address this in the next chapter.

The Government is committed to learning from patient safety incidents and improving the quality of investigations. The Government has initiated inquiries and investigations in the past, where there has been evidence of serious harm relating to specific healthcare settings and there is an important opportunity for system-wide learning. However, there have been calls for a wider scope of investigations into historical cases and the Department of Health and Social Care has heard from a number of families regarding their desire for redress in this area.

This includes the former Expert Advisory Group (EAG) for the Health Service Safety Investigation Branch, which made a recommendation to the Department of Health and Social Care "that the Secretary of State establish a process to address unresolved cases, aimed at providing truth, justice and reconciliation, to address the concerns of patients, families and staff affected". The Department is considering possible approaches and any implications before determining the next steps.

The Government agrees that more can be done to improve the quality of complaint handling specifically relating to serious incidents. For example, NHS Improvement will be reviewing the 2015 Serious Incident framework in order to provide national guidance on the systems, processes and behaviours that providers, commissioners and oversight bodies are expected to adopt to ensure the NHS responds more appropriately and effectively to serious incidents. In addition, the Healthcare Safety Investigation Branch is now conducting independent and professional led investigations in the NHS and is acting as an exemplar for high quality investigations. We believe over time, HSIB will raise the standards of investigative practice across the NHS that will benefit patients, families, healthcare staff and the tax payer.

Improving local complaint handling:

The Department of Health and Social Care should provide the Committee with an update on its progress on dealing with the "unfinished business" of local complaints handling the then Minister Ben Gummer MP identified in 2016, and the improvements that it has made. The Government should also ensure that once the Joint Committee scrutinising the HSSI Bill has reported that the revised Bill is introduced to Parliament as quickly as possible.

Following the Mid Staffordshire Public Inquiry in 2013, the Department of Health (DH) published Hard Truths in January 2014, which included a commitment for the DH to establish the Complaints Improvement Partnership. This started in 2015 to identify and take forward a strategy comprising further projects to improve the handling of complaints in the NHS. The Partnership originally comprised DH and system partners; NHS England, NHS Improvement, the Care Quality Commission, Health Education England and the Parliamentary and Health Service Ombudsman.

However, we now believe the focus must go wider than just complaints to include all forms of feedback, including that obtained during safety incident investigations, litigation cases and whistleblowing cases. It is also right that the strategy looks across the care system to include adult social care and public health services. The membership of the group has therefore been expanded to include NHS Resolution, the Local Government and Social Care Ombudsman and Healthwatch England, with work being concentrated on developing a Strategy for handling feedback across that wider care system.

It is important that service users across all care services receive the safest care possible and, when things go wrong, everyone within the system is open, honest, and looking to learn from their mistakes. It is equally important that service users, their families and carers are listened to, with their concerns taken seriously and properly addressed. We aim to be in a position to share details of the revised Strategy with the Committee in the autumn.

Future Public Service Ombudsman:

We recommend that the Government should invite the House of Lords to join the House of Commons in setting up a joint committee to conduct the pre-legislative scrutiny of the draft Public Service Ombudsman Bill as soon as possible. In its response to this report, the Government should provide the PHSO and LGO a date by which it intends to have the new legislation in place to allow them to plan with some confidence.

The Committee will be aware of the pressures on Parliamentary time in the run up to the UK's exit from the European Union. The Government has already made clear that the draft Bill will be brought forward as and when such Parliamentary time is available.

On the issue of pre-legislative scrutiny of the draft Ombudsman Bill, the Government's position has always been that this is a matter for Parliament to decide how they would like to take forward. Should the Committee wish to initiate such a process, then the Government will, of course, co-operate fully.

Correcting mistakes:

We [therefore] recommend that the government include unambiguous powers in the Public Services Ombudsman legislation to allow the Ombudsman to withdraw his reports in exceptional circumstances. This continuing legal uncertainty is another reason why the legislation should be brought forward at an early opportunity. If the Government intends not to legislate to create the Public Services Ombudsman in the forseeable future it should identify an alternative legislative vehicle to amend the existing legislation.

The PHSO's letter to PACAC on 1 February explained the Ombudsman has a practical, risk-based way of dealing with this issue in the absence of the legislation being brought forward. The Government included a provision in the published draft Bill (clause 4(6) and (7)) which allows the Parliamentary and Health Service Ombudsman to re-open reports if they are found to be flawed, and will consider any further findings from any pre-legislative scrutiny.

Appendix 2: Parliamentary and Health Service Ombudsman Response

We welcome the Committee's report, published in April 2018, on our work in 2016–17. We have studied its recommendations carefully, which will inform our work towards becoming an exemplary Ombudsman, as set out in the new three-year strategy we published earlier this year.

Outlined below is our response to each of the recommendations made in the Committee's report.

The Committee is in no doubt about the financial challenge that the PHSO faces. However, we also agree with the Ombudsman that before the PHSO can make the case for more funding, it will need to demonstrate that it is spending its current funding well. Given its past problems an external audit mechanism is required that will provide robust assurance of the value for money of the PHSO's operations to its Board, the Committee and the public. We recommend that the Ombudsman asks his non-executive directors to commission this, and report back to us. (Paragraph 20)

We are committed to providing robust assurance that we deliver value for money as a public body and can demonstrate our impact as effectively as possible. Our new strategy commits us to far greater transparency than we have delivered previously, with the ambition that by the end of the next 3 years we will be publishing the vast majority of our casework on line. Publishing our casework this way will help demonstrate our impact by highlighting what findings we are making, the recommendations we have made to remedy mistakes and improve services, as well as showing where the public sector is getting things right so that others can learn from best practice. In the meantime, we will also continue using our statutory powers to lay insight reports before parliament that highlight specific issues for PACAC and its sister committees to use in holding public services to account.

In addition to this work, the PHSO Board discussed this specific recommendation at its June 2018 Board meeting and agreed that a panel of independent experts be appointed to conduct a Value for Money study. The work will commence in July 2018 and report its findings in October. Peter Tyndall, Ombudsman of Ireland and President of the International Ombudsman Institute, has been invited to lead the panel.

We recommend that the Government should invite the House of Lords to join the House of Commons in setting up a joint committee to conduct the pre legislative scrutiny of the draft Public Service Ombudsman Bill as soon as possible. In its response to this report, the Government should provide the PHSO and LGO a date by which it intends to have the new legislation in place to allow them to plan with some confidence. (Paragraph 24)

We strongly welcome this recommendation. We believe that the draft Bill published by the Cabinet Office in December 2016 delivers the core principles necessary for a new Public Service Ombudsman to be successfully implemented.

We have already, however, worked with the Local Government and Social Care Ombudsman (LGSCO) to set out our views on how the draft Bill could be further improved before its introduction into Parliament. While we understand the pressures on parliamentary time created by Brexit that have put the passage of the Bill on hold, we would welcome the opportunity to at least use the extra time we now have available to explore these and other potential improvement further through a robust pre-legislative scrutiny process.

In the absence of this legislation, our new three-year strategy sets out how we will become an exemplary Ombudsman. We would welcome any timetable that Government could provide as part of the pre-legislative scrutiny process that sets out when any legislation could practically be taken forward to allow us to actively plan for the changes introduced by the Bill.

The Committee recommends that the PHSO publishes what average length of investigation it is aiming for and by when it intends to achieve it. The Committee will investigate the specific issues raised by the report into Ms Hart's death and the lessons to be learned, including from the failings in the investigation, at a later date. (Paragraph 35)

We acknowledged in our report '*Ignoring the Alarms*', published in December 2017, that we took too long to complete our investigation into Ms Hart's death. While some of the issues we deal with are complex and require detailed consideration of significant volumes of evidence as part of our investigations, we also accept that we have taken too long to close some cases.

Our new strategy commits us to investing in new ways of working, developing the skills of our staff, and speeding up our case handling to improve our overall service. It also commits us to introducing more early and alternative dispute resolution techniques into our service so that we can resolve cases more quickly and proportionately, especially those that may not require a full investigation.

Our initial focus, however, will be on successfully completing implementation of the new ways of working we have already started to put in place.

In 2018–19 we have set the following targets for resolving cases:

- 95% of intake enquiries closed within 7 days from receipt into the office
- 50% of cases closed within 13 weeks from receipt into the office
- 75% of cases closed within 26 weeks from receipt into the office
- 95% of cases closed within 52 weeks from receipt into the office

We welcome the Committee's focus on the issues raised by our report around improving NHS eating disorder services and how NHS organisations conduct and learn from serious incident investigations. We hope that this will help maintain momentum around the necessary improvements that need to be made in these areas.

Given the nature of the PHSO's work, and the number of complaints that it handles, it is inevitable that mistakes will be made, or the service provided to some complainants will slip below the standards the PHSO sets itself. However, these should be minimised, and the need to pay compensation rare. Complainants to the PHSO are already, by definition, dissatisfied with their treatment by the public sector so it is imperative the PHSO seeks to avoid causing further distress and further undermining public confidence in public services. We therefore welcome the approach to learning and feedback that is being implemented. We expect the PHSO to be able to provide evidence in the future of the improvements that have resulted. We also recommend that in future the PHSO publishes in its annual report how many times it has offered compensation as part of its wider commitment to transparency. (Paragraph 37)

We agree with the Committee that, when dealing with the thousands ·of enquiries and complaints that we receive each year, we may make mistakes in our handling of an individual matter. We are committed to both minimising such mistakes, as well as learning from them if they do occur. The need to become an exemplary Ombudsman service is central to our new strategy and we look forward to reporting to the Committee on our progress in delivering this.

We accept the Committee's recommendation to include information in our annual report on the compensation payments we have made to complainants. This has been included in our 2017/18 report.

We therefore recommend that the Government include unambiguous powers in the Public Services Ombudsman legislation to allow the Ombudsman to withdraw his reports in exceptional circumstances. This continuing legal uncertainty is another reason why the legislation should be brought forward at an early opportunity. If the Government intends not to legislate to create the Public Services Ombudsman in the foreseeable future it should identify an alternative legislative vehicle to amend the existing legislation. (Paragraph 42)

We support the inclusion of unambiguous powers in the draft Public Service Ombudsman Bill, or via an alternative legislative vehicle should this become available in the short term, for the Ombudsman to withdraw investigation reports in exceptional circumstances.

We therefore recommend that the PHSO does ask complainants if they perceive it as making decisions impartially as part of the Service Charter, and systematically seek and publish the view of bodies in jurisdiction. We support the commitment to equal access to draft reports and other information between all parties to a complaint. (Paragraph 52)

We agree with the Committee that it is vital that our decisions are seen as impartial, both by complainants and organisations we investigate. We are considering how we can best ascertain and report on their views about whether we make decisions impartially.

In addition, as we already do for complainants, we will shortly begin seeking the views of organisations we investigate more systematically about whether we are meeting our Service Charter commitments.

We anticipate publishing data in relation to these areas over the course of this financial year in line with our current Service Charter publication schedule.

We agree that the PHSO is not the correct body to carry out inquiries into historic cases. However, there remains a need for them to be addressed, both in the interests of the families involved and in ensuring that any safety lessons that can still be learnt are. We therefore endorse and repeat our predecessor Committee's recommendation; That the Department of Health and Social Care should develop a proportionate, time limited, mechanism to independently investigate and address those cases were legitimate questions or grievances remain. There is also a need to address local complaint handling and investigations in the NHS to ensure that there are fewer failed investigations in the future, we address this in the next chapter. (Paragraph 59)

We agree with the Committee's recommendation. As we have previously set out, such a mechanism is not something that PHSO has the capacity to undertake. As stated in our oral evidence to the Committee, however, we stand ready to be involved in discussions with the Department of Health and Social Care if they decide to explore how such a mechanism could work.

We also agree that more needs to be done to improve the quality of local complaint handling and investigations in the future. A key part of our new strategy is about working with others to improve how the public sector responds when things go wrong. We will consider a range of options about how we can best deliver this over the next 3 years, from sharing good practice to offering training to complaint handlers.

We therefore recommend that the Ombudsman publishes in his annual report how many of his recommendations are implemented as well as how many are accepted. In the longer term, we also recommend the PHSO seeks to evaluate the impact of its recommendations. (Paragraph 63)

A key objective of our new strategy is to increase the transparency and impact of our casework. We want to make sure that the recommendations and action plans that flow from our decisions are more visible so people can see the impact they make and other public organisations, such as regulators, can better use this information.

We have already committed in our strategy to begin publishing more data about what we do as a stepping stone to achieving our objective to deliver greater transparency. We are currently exploring how we can publish information on a quarterly basis regarding our casework and over the course of this year our ambition is for this to include more information about compliance with our recommendations. We will share this data with the Committee as it is published to inform its scrutiny of our work, and seek to reflect this information in our annual reports from 2018/19 onwards.

The Department of Health and Social Care should provide the Committee with an update on its progress on dealing with the "unfinished business" of local complaints handling the then Minister Ben Gummer MP identified in 2016, and the improvements that it has made. The Government should also ensure that once the Joint Committee scrutinising the HSSI Bill has reported that the revised Bill is introduced to Parliament as quickly as possible. (Paragraph 6)

We look forward to working with the Department of Health and Social Care and other stakeholders to improve local complaint handling.

We also welcome the draft Health Service Safety Investigation Bill (HSSIB) and believe the new HSSIB can make a vital contribution to improving patient safety.

We have highlighted in our casework the need for standards for incident investigations, and therefore particularly welcome that the Bill would place a duty on the HSSIB to develop standards and give advice or assistance to others. As we have highlighted to the joint Committee scrutinizing the draft HSSIB legislation, it is particularly important that, as the Bill progresses through Parliament, no amendments are made that would cause any confusion for NHS trusts and the public on how PHSO relates to the HSSIB. This is particularly important because we can conduct investigations into complaints about safety incidents and can also consider complaints about HSSIB, which the Bill places in our jurisdiction.