Parliamentary and Health Service Ombudsman

Clinical Advice Review Final Report

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Foreword

As I set out when we launched our consultation last September, advice from healthcare professionals plays a crucial role in helping inform the Parliamentary & Health Service Ombudsman's (PHSO's) decisions on the complaints it handles. Making sure that this part of PHSO's process gathers the right evidence and analyses it properly is, therefore, hugely important.

We received many thoughtful and constructive responses to our consultation from a wide range of complainants, and from medical professionals, PHSO staff, organisations investigated and bodies such as the General Medical Council, the Patients Association and the Medical Defence Union.

We had very helpful meetings with PHSO staff, clinicians, representatives from NHS Trusts and with people who have brought complaints to PHSO. I was grateful in particular to the complainants who came to meet Sir Liam and me in person during the consultation period to tell their story. As Sir Liam mentions in his report, PHSO has now surveyed thousands of complainants as part of its Service Charter, the majority of whom are content with how their case was handled. We did, however, hear clear evidence from the complainants Sir Liam and I met that in some cases there are clear improvements that can be made to PHSO's work. Their views were strongly augmented by the dozens of written submissions from complainants and others that we received during the consultation.

The report that Sir Liam has produced reflects that there are ways PHSO can improve its service and sets a number of challenges for the organisation to meet. As Sir Liam notes in his report, the work that is needed is not a quick fix. It requires careful design and implementation to ensure that in addressing one problem, new ones are not created, such as disproportionately lengthening the time it takes to complete casework.

I am confident that the Review Team's response to Sir Liam's recommendations and the additional changes we have proposed to give effect to his work provide PHSO with a coherent package of reforms that will improve how clinical advice is used in casework.

Separately to this full consultation analysis and final report, PHSO has produced a document summarising this Review's findings, their response to our recommendations and an implementation plan explaining what comes next.

PHSO's role in providing individual redress to people who have suffered injustice and helping drive improvements in public service at both the UK level and across the NHS in England is hugely important. Much of what PHSO and its staff already delivers is of an incredibly high standard. In PHSO's 2018-21 strategy, the organisation set out its ambition to become an exemplary Ombudsman service and what it will deliver to get there, and I am conscious that it has a significant amount to deliver over the next two years in order to meet the objectives it has set.

Delivering the recommendations outlined in this report will be an important part of that journey. I look forward to scrutinising the progress that is made in my role on PHSO's Board.

Sir Alex Allan, KCB

Chair of Clinical Advice Review and Non-Executive Director

Introduction

The Parliamentary and Health Service Ombudsman (PHSO) is the last resort for people who are dissatisfied with the treatment or service they have received – be it from government departments, their agencies or an NHS organisation. Each year the Ombudsman is contacted by tens of thousands of people to look into complaints where they believe there has been injustice or hardship because an organisation has not acted properly or fairly, or has provided a poor service and not put things right.

Usually people must complain to the organisation first so it has a chance to put things right. If, after an organisation has responded, an individual believes the dispute or situation remains unresolved, they can ask the Ombudsman to look into the complaint. If there has been maladministration or injustice, the Ombudsman can make recommendations to put things right. Organisations failing to act on any recommendations can be called before Parliament to be held to account.

Many complaints about the NHS relate to the clinical treatment received by the person complaining. In these cases, it is important that the Ombudsman can understand the clinical issues around the complaint. In summer 2018, fulfilling a commitment made in his new three year strategy, the Ombudsman established a Review Team looking at the use of clinical advice in the Ombudsman's case work, and in particular in those cases where advice from an independent clinician has been sought.

The Review Team was led by a Steering Group chaired by Sir Alex Allan and its membership included Julia Tabreham, both non-executive members of the PHSO Board. It also included a mix of senior PHSO staff and was supported by a small, internally resourced, secretariat. In addition, Sir Liam Donaldson, the former Chief Medical Officer for England and currently the World Health Organisation's Envoy for Patient Safety, agreed to act as an independent adviser to the Review. This is the Review Team's final report and our Terms of Reference can be found at Appendix 1. Sir Liam's report is available on www.ombudsman.org.uk.

To inform our work, we issued a consultation in September, the findings from which we have summarised here. We asked for feedback in our consultation on the principles that underpin the Ombudsman's use of clinical advice as well as the level of information about clinical advice provided to complainants, the organisations investigated and the general public. Views were also sought on the new Clinical Standard used by the Ombudsman that was published in August 2018. A background paper was also published with detail on the PHSO's service.

We have not repeated much of the detail included in the consultation and background papers in our final report, except where this context is needed to help explain our final recommendations. Both of these documents remain available on www.ombudsman.org.uk.

Our consultation

We received 167 responses to our consultation, which ran from 14 September to 15 October 2018. Of these, 84 were from individual complainants, 11 were from medical professionals and organisations (including PHSO's own advisers) and 6 were from patient representative and advocacy bodies

We also received responses from organisations such as the General Medical Council (GMC), the Medical Defence Union (MDU), the Medical and Dental Defence Union Scotland (MDDUS) and Action against Medical Accidents (AvMA). In terms of the patient representative bodies, the Patients Association response also incorporated feedback from 36 former PHSO complainants who had also used their service. We received 2 separate responses from 'PHSOtheFacts' and its coordinator, which summarised a variety of views. We also received 15 responses from our casework staff.

In addition to these written responses, members of the Review Team Steering Group and the Independent Adviser attended two roundtable discussions with clinical advisers and caseworkers from PHSO during the consultation period. Separate roundtables were also held with a small number of representatives from the organisations PHSO investigates, as well as with a group of complainants. The latter were identified by emailing all complainants whose case with PHSO had concluded in the last 18 months and inviting a group of those that responded to our offices.

In addition to this engagement, the Independent Adviser also held a number of one-to-one discussions with staff at all levels across PHSO to help inform his understanding of how clinical advice is requested and used across the organisation. He also considered a number of individual cases on paper and through discussion to inform his work.

We have outlined below the questions we posed at consultation and a summary of the key points that were made in the responses we received.

Views on PHSO: Clinical assessment of complaints

Q1: What are your impressions and views on the clinical assessment of complaints, particularly whether they seem generally comprehensive, well-founded, and authoritative? Examples from complainants or from organisations that PHSO investigates of their experience of clinically-based reports or communications would be particularly valuable.

We received a range of responses to this question, which fell into two key themes.

The comprehensiveness of advice

While a small proportion of the complainants that responded suggested that the clinical advice used in their case was comprehensive, the majority argued otherwise. There was a clear perception that came through in both the written responses and that was echoed in our roundtable, that from the complainant's perspective clinical advisers do not always understand the full context of their case, which has the effect of undermining trust in this stage of the Ombudsman's process.

A number of complainants gave specific examples from their cases where they believed the advisers were not aware of the full history of their case or they did not have access to all of the relevant clinical material. They believed this had wrongly skewed the

outcome of their complaint and noted that a lack of communication during the investigation process meant that they had been unable to feed back their concerns until they received the provisional views on the case.

In our roundtables with caseworkers and clinical advisers, it was noted that caseworkers are required to themselves look at key guidelines and other material that will help inform their approach to a case. This means that, particularly for more experienced caseworkers, requests for clinical advice will often focus on quite specific elements of a case where they need extra support evidence to inform their decision making process. This also means that clinical advisers will only receive some, not all, of the documents linked to the case, which will be reflected in the advice they provide.

The consistency and quality of advice

The GMC noted that their process for using advice in 'fitness to practice' hearings shared a number of similarities to the Ombudsman's clinical advice process. This included taking a flexible approach to commissioning and documenting the advice depending on the complexity and nature of the case. The GMC noted that, *"the decision maker should balance the information available to them. This applies to both clinical factors and non-clinical factors, such as witness evidence, or information relating to the environment within which the alleged incident occurred"*.

A number of complainants, the Patients Association and the Medical Defence Union raised concerns about the quality of the clinical advice being received and the consistency achieved across the Ombudsman's cases. Questions were raised about whether caseworkers were asking clinical advisers the right questions. Feedback also suggested that key elements of the scope of complaints had not been reflected, as when provisional views and final reports were issued they missed key elements of a case that complainants thought were being investigated. This issue was also raised by some NHS organisations, who suggested that greater transparency and dialogue about what questions have been put to advisers and how these have been answered would be welcome.

Feedback from caseworkers and clinical advisers themselves also indicated that the approach to giving clinical advice was not always consistent across the organisation. Some advisers noted that they would only provide advice on the questions they were asked. Others noted they would advise on wider issues if they felt that was appropriate based on the evidence that was provided to them on the case. Advisers also noted that there was inconsistency in the amount of documentation provided to them on a case, with some just receiving the key clinical records. At other times, they would also receive the original complaint and organisational response as additional background.

There was a clear appetite among both caseworkers and advisers in the roundtable discussions for greater opportunities to provide more structured feedback on both the questions being asked and the advice provided to help drive continuous improvement and greater consistency. Both complainants and NHS organisations, as well as bodies such as the Patients Association and MDDUS, also displayed a strong view that there should be greater visibility of what is happening at the point clinical advice is being requested and received, so that there is the opportunity to input views at these stages of the process. The Patients Association noted that this should also include assurance of the qualifications and appropriateness of the adviser being used.

Q2: How should clinical advice received by PHSO be balanced with other evidence received from complainants and from the

organisations that PHSO investigates? In the reports that you have read do you feel that the assessment of, or judgements on, complaints adequately and fairly balance clinical and non-clinical factors?

There were again a small number of key themes that emerged from the range of responses we received and that were supported by the evidence we heard at our roundtable discussions.

Independence and impartiality

A significant number of the complainants that responded said that their evidence and testimony appeared to be given less weight than that of the organisation complained about. Many felt 'disbelieved by default'. They also said that much of the evidence they submitted in relation to their case, including medical notes, letters, and diary entries was not properly considered. In the roundtable discussion we held with complainants, there was also the suggestion that the complainants' account was queried and questioned more than was necessary.

In a similar vein, AvMA noted the importance of giving equal weight to the complainant's evidence and story to that received from the NHS itself, while the Patients Association said, *"caseworkers must be ready to challenge expert advice like any other source of evidence, particularly if it appears to be at odds with the weight of other evidence".* An NHS body said that at times it appeared that the evidence from clinical advisers was not challenged by caseworkers even if it was clearly not appropriate and asked for, *"greater clarity surrounding the clinical adviser's identity, their background and their relationship with the NHS".*

Caseworkers and advisers noted that it was often a difficult balance to strike between the weight of evidence that was received from both sides of the complaint. The organisation being investigated would often have a far greater amount of written evidence than the person complaining, who at times only had their personal testimony, which might mean they were at a disadvantage. One clinical adviser noted that while it was always important to remember that clinical notes can contain mistakes and inaccuracies as often as verbal evidence, this may not always be at the forefront of the adviser's mind.

Some caseworkers proactively suggested that more could be done in reports to demonstrate the variety of evidence that has been received while also providing more detail about how it has informed the final decision making process.

Absence of records and emphasis on clinical advice

It was frequently noted that an absence of records from organisation's being investigated impacted more negatively on the complainant than the organisation that failed to provide them. The fairness of this was repeatedly questioned. Advisers themselves also noted that there were often key documents missing from the records they received on a case, while some caseworkers agreed that more could be done to criticise organisations that demonstrated poor record keeping.

A small number of complainants also suggested that too much weight could be placed on clinical advice, particularly where documents were not available from the organisation to inform the caseworker's view. The Patients Association suggested that more should be done to challenge bodies that did not provide material to ensure that information was not inappropriately being withheld.

The MDU suggested that, in their view, equal weight seemed to be given to accounts from the different parties. However, contrary to complainants, they said *that in a significant*

number of cases they had seen '*expert evidence*' and *'detailed explanation'* which they had assisted clinicians to include in their response to our investigations being disregarded in final reports and decisions.

Insufficient focus on systemic and non-clinical factors

A number of complainants suggested that adequate consideration is not given to wider evidence, including human and social factors, to balance against the clinical factors in a case. Some of the medical professionals that responded raised similar concerns. Both groups also suggested that more should be done to encourage clinical advisers to raise and escalate any systemic issues they identify, even where these are outside the scope of the advice requested. One emergency medicine clinician who responded also said that local pressures, such as funding or staffing shortages, should form a greater part of our considerations.

Q3: Based on your experience, in what other ways could the way clinical content that underlies the Ombudsman's decision-making be improved? Why do you think this is necessary?

The responses to this question built on some of the themes and issues emerging from the first two questions.

Increasing complainant input

We heard consistent evidence from complainants and representative bodies that they should be more routinely involved throughout the process of the complaint, with input proactively sought by caseworkers. They said that increased communication would allow increased opportunities for raising concerns or queries about the handling of the complaint and help them feel more involved in the process.

Many of the complainants and the healthcare professionals that responded also suggested that it could be helpful to come together with the caseworker to discuss the case. A number of caseworkers also felt that greater involvement of the complainant in particular throughout the process could be helpful. This was echoed by the Patients Association, who said that here should be: *formal opportunities for patients to raise concerns and request that work is redone if they feel mistakes have been made in scoping a request for clinical advice, or if an adviser lacks suitable expertise to advice on the case.*

The suitability of clinical advisers

A significant amount of the complainants and some NHS employees who responded said that they had been uncertain whether the adviser used in their case had the appropriate specialism, experience or level of seniority to provide advice. This was especially the case where the condition was particularly rare, with AvMA noting that their own database of clinicians may be a useful resource the Ombudsman could refer to.

There were also concerns from a small proportion of complainants about the lay nature of our caseworkers. This group were concerned that lay caseworkers, who are not usually trained medical professionals, were not adequately experienced to make a decision on their case. The MDDUS also raised concerns about the suitability of advisers, stating that in order to, *"understand the nature or impact of a clinical scenario, only a GP expert is placed to determine whether the actions of a GP under investigation were appropriate".*

Transparency

Q4: What are your views on the issues outlined in the section on transparency, in particular about how the new final investigation reports can support better understanding about how and why clinical advice is used; and whether clinician's names should be routinely published? Do you have any evidence or examples you can share with the Review to inform your view?

While almost all complainants responding to this question supported greater transparency, there were mixed views on the merits of naming clinicians. Some complainants suggested that clinicians should be named in all circumstances, while others thought that sharing the qualifications and experience of the adviser was sufficient. Some complainants in the roundtable discussion also noted that they understood the concerns expressed by some advisers about the effect naming them could have, leading to them being approached inappropriately in their other jobs. One complainant in their written response suggested a directory of advisers could be published annually.

For complainants, the most important reason for naming clinicians was proving there was no conflict of interest, as well as to encourage accountability for the advice provided. There was also strong feedback from a small number of complainants, including at our roundtable, that the Ombudsman was not sufficiently independent from the NHS and that using NHS employed clinicians was an example of that. At the roundtable, it was noted that there was little practical alternative to using NHS clinicians. It was also felt that more should be done to demonstrate the independence of the clinician providing advice from the individuals and bodies involved in the complaint.

Bodies such as MDU, MDDUS, the Patients Association and AvMA supported naming clinicians. The GMC noted that they felt naming clinicians should be proportionate and that providing the specialism and the assurance that there is no conflict of interest is the most relevant information to provide. If a name is requested by a party, they said that they would take the approach of assessing the appropriateness of providing that information on a case by case basis. A clinician from NHS England suggested that, *"with regard to clinical advisers being named my view is they should be. As clinicians should all be accountable for the advice we give (via the appropriate channels of course). The process is also less transparent if the advisers are not named".*

The individual healthcare professionals that responded did not generally see the need to name clinicians, but agreed that greater transparency around this stage of the process would be welcome, for instance by routinely sharing advice and the questions asked. This view was echoed by the organisations that took part in the roundtable discussion.

Internally, the vast majority of advisers and caseworkers were against naming clinicians, regularly highlighting the concern of harassment on social media and in their other NHS roles as a reason. A lead clinician gave an example of where this had happened recently when a name had accidently been leaked. There was general agreement that new safeguards would be needed should clinicians be named, including a strong, clear policy for dealing with the small minority of vexatious complainants.

A number of caseworkers argued that in their experience, sharing the qualifications and existing process of managing conflicts was usually sufficient to reassure complainants when they had questions about who was providing clinical advice. They also noted that it was important that there was clarity that caseworkers led the investigation and that communication needed to be channelled through them.

The Clinical Standard

Q6: Do you have any views on how either the standard itself, or the contextual information preceding it, could be improved to increase this clarity?

There was some negative feedback on the new Clinical Standard from organisations such as the MDU and MDDUS, who said that the Ombudsman was setting the bar for their investigations too high. MDU expressed that the Ombudsman should define *more clearly what is considered as 'good clinical care and treatment', so that clinicians know how any standard(s) will be applied, and experts understand them.*

The MDU also suggested that the Standard, *'does not help us to explain in advance to our members what the Ombudsman expects of them, what good clinical care and treatment means and what clinical standard(s) will be applied to their practice'.* Similarly, while MDDUS recognised that the Ombudsman, *'is empowered by Parliament to set his own standard to support decisions regarding service failure',* they noted some *'residual concern'* about how the Standard would be applied in practice.

There were some comments that setting the bar higher than that for clinical negligence cases was unfair. It was also suggested that this led to a lack of clarity about the standards to which clinicians were being held, increasing 'pushback' from those being investigated.

Other respondents gave significant support for the new Clinical Standard. Representatives from the Trusts that attended our roundtable discussion noted that alongside recent guidance from the Ombudsman on financial remedy, the Standard had increased understanding of PHSO's approach in general. AvMA and the Patients Association also felt the new Standard was clear.

Other key themes that emerged from the consultation are outlined below.

Clarity of language

Some complainants and healthcare professionals did note that the language in the Clinical Standard was not sufficiently clear as it was either too technical or did not provide sufficient context. The GMC queried whether more 'plain English' could be used to help non-medical professionals understand how the Standard would be applied.

The GMC went on to make some specific suggestions for phrases that could be changed to help with this, for instance replacing *'inquisitorial process', 'the adversarial approach taken by court',* and references to the legal standard in clinical negligence cases.

Cases where there are no guidelines

Some complainants and healthcare professionals fed back that the Standard does not account for when there is an absence of guidelines, as well as how to decide which guidelines to use. In our roundtable discussion, complainants raised concerns about how the Clinical Standard could be interpreted by clinical advisers, particularly on the seemingly wide scope that they have to accept deviations from standards.

Internally, the majority of caseworkers and advisers understood and supported the new approach, and they felt that the new Standard did lead to a greater focus on guidelines and evidence, which was helpful. There was recognition that it was going to be challenging to explain to complainants why it may be acceptable to deviate from guidelines. In the roundtable discussion, caseworkers did also note that in applying the new Standard, it had facilitated a more open and constructive conversation with the organisations being investigated as they were now clearer about what was needed.

The GMC also noted that the references to non-clinical guidelines, such as the Ombudsman's Principles of Good Administration, could benefit from further explanation.

The Background Paper

Q7: Do you have any comments or views you wish to feed in on the recommendations and proposals in the Background Paper?

There was widespread support for the majority of proposals included in the background paper that we published alongside our consultation.

The Patient's Association and the majority of complainants and healthcare professionals that responded were particularly supportive of clinical advisers having sight of how their advice has been incorporated into the provisional views shared by the Ombudsman.

The Patients Association was also supportive of the new accreditation programme that is being developed for senior caseworkers, as were the MDU and GMC. Some complainants did suggest that it was important that this programme equip caseworkers with sufficient medical knowledge to deal with cases.

There was general support for the increased quality checks that were proposed, particularly by formalising how caseworkers and clinical advisers can comment on each other's work. MDU, MDDUS and GMC also proposed increased quality auditing as well as establishing a specific forum where poor practice or concerns could be reported. The Patients Association also suggested that complainant feedback should be better built into the process.

There was feedback from some complainants that the language used in final reports should be more accessible in terms of using plain English. Others suggested using terms such as 'pain', 'harm' and 'partly upheld' can be too vague and diminish the seriousness of a complaint and the outcome that has been achieved. Some also suggested that there needs to be further explanation as to why a complaint has not been upheld or is out of remit. It was also noted that more clarity about how organisations were being held to account where there had been failings should be provided.

Our recommendations

We have considered the consultation responses we received carefully. We have also had the benefit of the views from Sir Liam Donaldson, our Independent Adviser, as set out in the report he prepared for us following consultation.

This chapter sets out the Independent Adviser's final recommendations, our response to these and the associated changes we feel should be made in relation to them. It also addresses outstanding issues he has not addressed, but that are relevant to our wider terms of reference or that arose during consultation, and any further changes we believe could be introduced to address these.

We recognise that the recommendations of our Review will need to be considered alongside a range of other activity PHSO is conducting to improve its service in line with its three year strategy. This is an important package of recommendations, however, that will fundamentally improve how PHSO delivers a crucial aspect of its service. We have accepted the principle of everything the Independent Adviser has set out in his recommendations, and the majority of the detail, and have built on these ourselves following our own detailed analysis. We are confident that PHSO will embrace and rise to the challenge we have presented.

The Independent Adviser's report

In developing his report, the Independent Adviser has reflected on some fundamental policy issues around how the NHS complaints system has evolved over time. These stand outside the Terms of Reference of the Review itself and as such are not addressed in this chapter. We welcome them, however, as a useful reflection that will inform future policy thinking in this area.

The Independent Adviser has made the recommendations outlined below in his report, to which the Review team has responded as set out beneath each one. A full copy of the Independent Adviser's report, which includes more detail on some of his recommendations, is available on www.ombudsman.org.uk/clinical-advice-review.

Recommendation 1: Clinical Advisers should be much better integrated into casework

The Review Team fully support this recommendation. This is an issue which emerged very clearly in responses to the consultation and in our discussions with clinical advisers. It was also highlighted in Sir Liam's analysis of some individual cases.

This would not only improve the clinical advice process, but would also generate better quality of management insight into how things are working in practice. It would also encourage continuous learning between caseworkers and clinical advisers.

The changes we recommend, and that should be built into PHSO's service model and training, where they do not already exist, are that:

- The caseworker should always indicate to the clinical adviser where on the file they can find the complaint to the organisation and the organisation's final response so that they can consider this if needed, along with any other relevant evidence, such as case notes from the organisation being investigated.

In line with work previously completed by PHSO's lead clinicians, but not yet implemented, a survey should be established where clinical advisers are invited to provide feedback on the questions they have received from caseworkers. Caseworkers should also be able to provide feedback on the clinical

advice they have received. Both of these surveys should be embedded in PHSO's quality assurance processes. The results of these internal surveys should also be shared with relevant managers to inform performance management and process improvement discussions with both caseworkers and clinical advisers.

- Clinical advisers should always see the provisional view and ensure that their views are properly recorded (see also recommendation 4 below).

While points such as the first bullet above are in line with what PHSO would already expect, we and the Independent Adviser heard evidence that this does not always happen in practice. The surveys that PHSO has already developed should be updated to ensure that clinical advisers and staff can provide general comments on such wider process points so better management information is available about how the system is working in practice. The quality assurance processes that PHSO uses more widely are already being reviewed as part of its improvement activity. This should also look at the frequency of PHSO's existing Peer Review and other quality measures, alongside the recommendations we have made above in relation to increased input from caseworkers and advisers on the quality of each other's work. Doing so will make sure that the full spectrum of quality assurance in this area remains proportionate and robust.

Sir Liam recommends that PHSO's in-house advisers should work with caseworkers at the outset of a case to help develop an understanding of care 'in the round'. He also recommended that when the specialist adviser reports are received, the clinical adviser should be represented at a multidisciplinary meeting arranged by the caseworker, at which the preliminary view will be debated and formed. We are conscious that implementing these proposals for all cases could add significant time to the handling of many of PHSO's more straightforward cases. In addition, the greater involvement by clinicians throughout the process that both the Independent Adviser and the Review Team itself recommends in other areas could address many of the issues that have been raised in the context of these recommendations.

We recommend that an approach on these lines should be piloted to understand what affect this would have on the time taken to reach decisions on cases, as well as to assess the potential cost that such changes may bring. The pilot should trial greater involvement of clinicians at the PHSO's assessment stage to better understand the benefits of doing this. It should also trial multidisciplinary meetings once specialist advice has been received. It may be appropriate, for example, to test this approach on some of the most serious cases that PHSO receives, such as where there has been an alleged avoidable death. The benefits may include greater satisfaction with the outcome of complaints, and a reduction in the time taken to finalise decisions or to deal with issues that arise.

We are aware that, subject to the outcome of the pilots, some elements may only be able to be rolled out across all cases if significant extra funding is secured during the next Comprehensive Spending Review. This may be needed to fund additional in-house clinical adviser posts or an increase in the amount of advice that is commissioned from advisers from outside the organisation. If such funding is not secured, PHSO should set out in the relevant annual report when the decision has been made, which recommendations from the Review it has not been able to deliver in full as a result of a lack of funding.

Sir Liam also recommended that clinical advisers should help choose specialist advisers required whether internal or external. This is already standard practice, and we support it.

Recommendation 2: There should be greater contact and better communication with complainants

The Review Team agrees with the thinking behind this recommendation, which was one of the strongest themes that emerged from our consultation. Although PHSO's existing Service Model prompts caseworkers to involve and update complainants on the progress of their case, it is clear that in practice this is too frequently not done well enough.

Effective and consistent communication, particularly with complainants, throughout the lifetime of a case would help ensure everyone involved felt sighted on progress and, where appropriate, the developing thinking of the caseworker. Better visibility of this and an ability to challenge, comment and ensure that the full scope of the complaint is fully understood and being dealt with could greatly reduce some of the friction that can occur at the conclusion of a case.

We were particularly struck when meeting complainants about their general frustrations regarding the lack of information they received as their case progressed between the scope of their complaint being received and the stage when they received the Ombudsman's provisional views. This went beyond just the issue of knowing who the clinical adviser on their case is.

The direct evidence we heard is supported more widely by PHSO's Service Charter data. Although a majority of complainants are generally positive about the service they receive in most of the areas surveyed, it is also notable that in 2017-18 a quarter of complainants did not agree that they were regularly updated on the progress of their case. Almost 40% also said that they did not agree that PHSO shares the facts with them and discusses what they are seeing during the lifetime of the case.

These issues do appear to be undermining trust and confidence in the Ombudsman process among a significant number of complainants. We are aware that work is underway within PHSO to explore whether an online system could provide more 'real-time' information to those involved in a complaint as it progresses through the system.

Depending on the timescales for this work, our view is that a number of practical interim steps could be taken to improve the level of communication with complainants and the organisations being investigated (and could be built into any future online system).

Some of these simply require more consistent implementation of PHSO's existing Service Model by caseworkers and include:

- When a case first proceeds to the investigation stage, complainants should be provided clear, accessible information that clinical advice may be requested, the general purpose of this and the independent status of the clinicians we use.
- Where clinical advice is requested at any stage of the case, this fact should be shared at that point with the complainant and the organisation investigated, along with a commitment that the advice and the questions asked will be shared once they have been received and before any provisional views are issued. This is in line with the recommendation of the Independent Adviser.
- When communicating this information, the qualifications and experience of the adviser and why they have been chosen (e.g. because they are specialist in a particular area, or because the questions are sufficiently general about an issue such as consent that a non-specialist is appropriate) should also be shared.

This approach would see information shared more consistently and provide greater insight and an opportunity to input into the process as it evolves across the lifetime of a case. It would also mean that better informed representations could be made in the period that the caseworker was drafting their provisional views. This could inform how they are formulated and subsequently explained, which in turn could reduce the number of questions that asked after they are issued.

We are aware that these changes may have a significant impact on the current delivery of PHSO's service and that they will require changes to process, internal guidance and staff training. They will also change the culture of the organisation, which will not happen immediately. Our view is that it would be possible to pilot these recommendations to identify any ways that the impact on, for example, case duration could best be minimised. As indicated in our response to Recommendation 1 above, a pilot approach would also allow for an assessment to be made of the cost associated with such a change. This would enable PHSO to take account of such costs in its final decision about when and how to implement these changes and whether, for example, they should only apply to certain types of cases, for example where there are allegations of serious harm or avoidable death.

The Independent Adviser has also raised in his report the question of whether clinical advisers should meet complainants.

It is our view that advisers meeting complainants should not become a routine part of the process. Most fundamentally, this could undermine the caseworker's role as decision maker. In addition in most cases this would not be proportionate and it could add significant cost into PHSO's service in relation to clinicians' time, which given the 24% cuts it is in the middle of implementing would not be affordable.

We agree with the Independent Adviser that there should be equality of access and if the Ombudsman's clinical advisers have direct contact with a clinician regarding a case, the same opportunity should be afforded to the complainant (and vice versa). In addition, in line with the approach set out in response to the previous recommendation, if significant extra evidence is provided by the organisation investigated that has not been seen by the complainant, they should be made aware of this so that they can present any views they have in respect of this. Similarly, if this extra evidence requires further clinical advice, the complainant should be involved as indicated in our response to the previous recommendation.

We also sought views at consultation on our approach to naming clinical advisers. The Independent Adviser does not provide a final recommendation on this issue in his report and we have therefore set out our views on this in the next section of this chapter.

Recommendation 3: The opinions of patients and family members on clinical events should be given proper weight and emphasis

The Review Team fully supports this, which was something that emerged strongly from our consultations. Additional guidance should be developed to help caseworkers understand how to both balance the evidence they receive from all parties in a case and how this is subsequently explained in the provisional views and final reports that are issued. Contemporaneous clinical records are a hugely valuable source of evidence that often provide essential material that allows PHSO to form a decision. We have heard evidence, however, that it is often unclear how these are balanced against personal recollection and how that balance does and should shift in cases where such clinical evidence may be missing or disputed.

This guidance material should also be made available externally, both online and in the information provided to complainants at the outset of their case explaining how the Ombudsman works. This will help make clear from the earliest point what evidence is needed and how it informs the decisions that are made. PHSO's training programme and the related cultural materials produced for caseworkers should also be adapted to make sure this guidance is incorporated.

We note that PHSO has also committed in the third objective of its 3-year strategy to improve frontline complaint handling by working *"with advocacy organisations, bodies like the National Guardian and Healthwatch and complainants".* As part of this work, it should consider how relationships could also be developed to ensure more information about its service is shared with citizens at the right point of the complaints process to raise awareness of its role, how it makes its decisions and the types of evidence it will seek to inform these and the types of remedy it can offer.

Recommendation 4: Those providing the clinical advice should agree how their advice is used in the final report.

As noted under Recommendation 1 above, the Review Team fully supports this recommendation.

In the background paper published alongside our consultation, we also recommended that clinical advisers should routinely be sighted on the Ombudsman's provisional views and, where relevant changes have been made, final investigation reports. In addition to the Independent Adviser's recommendation, the evidence we received during the consultation from both advisers themselves as well as external stakeholders indicated that this would provide greater confidence that no mistakes have been made in interpreting this advice, offering wider benefits.

In addition, concern was expressed by some clinical advisers about whether the right balance was being struck between the increased use of documented discussions as opposed to requests for formal written advice. Sharing provisional views with advisers before they are issued would help ensure that, irrespective of which approach was taken, they could confirm their advice had been accurately translated by the caseworker in the context of the wider case.

We also acknowledge some concern was expressed by caseworkers during the consultation about the impact sharing their provisional views could have on their role and the delay it could add to case handling.

We therefore also recommend that it is clear in the internal communications and guidance that supports any such process changes, that this in no way undermines the role of the caseworker as the decision maker on the case. It will, however, provide adviser's with the opportunity to ensure that their advice has been applied accurately to the matter being investigated and provide them an opportunity to raise errors of fact or application with the caseworker.

While we accept that this may add some extra time into the handling of cases, the evidence we heard indicated that it would make provisional views more robust and may also reduce the number of challenges PHSO receives at this stage of its process. Our view is that this is an important change, however, it may also be appropriate to pilot it on some of PHSO's more serious casework to understand whether there are ways to reduce any time that may be added to case handling before it is rolled out across all casework.

Recommendation 5: The organisation should take a systems based approach to investigating the causes of poor care

The Review Team agrees that caseworkers should be appropriately equipped to identify the relevant factors that account for service failure in the exercise of clinical judgement and in standards of care. This is important to give a balanced picture of the extent and nature of any failings that have occurred, which in turn is vital in informing any proposed remedies and learning to prevent recurrence.

We are aware that PHSO's current service model guidance includes the need to consider if systemic as well as individual remedies are required to address service failure. Its professional training also emphasises the need to consider the root causes of failings but it does not currently provide an in depth focus on systems approaches and root cause analysis.

We agree with Sir Liam that PHSO could do more to ensure consistent and appropriate consideration of systemic and other relevant factors when investigating clinical failings. To address this, we recommend that in light of the Independent Adviser's recommendations, a comprehensive assessment of organisational policy and capability in this area should be conducted. The aims of this assessment should be to determine:

- A clear internal policy position on the appropriate and proportionate use of different methods of investigation in PHSO's processes.
- Identification of any changes needed to ensure PHSO has the capability to consistently apply the policy, including changes to guidance, training and recruitment.
- Engagement with bodies such as NICE and the GMC whose work as it evolves could inform the Ombudsman's own approach to investigation and the evidence base it uses.
- Identification of any necessary changes to PHSO's quality assurance processes to ensure performance in this area can be monitored.
- Identification of any necessary changes to PHSO's caseworker accreditation programme to ensure it assesses the appropriate range of investigative competencies.

It is likely that this assessment will also involve further discussions with other ombudsman and bodies such as the new Healthcare Safety Investigation Branch to understand if there are new or existing techniques that can be incorporated into PHSO's approach in this area that are not currently used. Should this work lead to any changes to PHSO's Service Model or other guidance for staff, these should be published on its website in line with the current approach to such updates.

PHSO should also continue developing the Insight products it produces when it identifies significant service failures to ensure that the learning from its work is shared as widely as possible. Its recent report on the treatment of eating disorders, for example, has led to significant steps across a range of national bodies to improve treatment of these conditions. It is important, particularly while it develops its approach to publishing all of its casework, that PHSO continues to produce such reports where its evidence indicates that there are system-wide problems so that it can share this learning as widely as possible.

Recommendation 6: Clinical advisers should be encouraged to identify any serious problems in the care even if it is not an area covered by the complaint

The Review Team agrees that there should be greater interaction between clinical adviser's and caseworkers over the lifetime of the case. A number of the recommendations we have made in response to the Independent Adviser's views will provide for this.

We also agree that clinical advisers should be able to discuss with the caseworker any issues they feel are not covered by the questions they are being asked. Should an Adviser raise an issue that is not part of the original complaint, but that the caseworker agrees is a significant matter, the caseworker should then take the opportunity to discuss this with the complainant. This may then lead to an agreement that the scope of their complaint needs to be clarified to make clear that the additional issues that have been identified are sufficiently captured by it. PHSO's internal guidance and training should be updated as needed to make this clear.

It is important to note that at present unless the complainant agrees to this expansion the Ombudsman has no 'own initiative' or similar powers to proactively expand the scope of the complaint itself. Any updates to PHSO's guidance or training in this regard will also need to be clear on this point.

Recommendation 7: The tone and content of final reports and letters conveying decisions to complainants should be improved

The Review Team agrees with this recommendation.

As part of its 3-year strategy, PHSO has committed to publishing the vast majority of its casework. We are aware that, in order to deliver on this commitment, work is already underway to scope a pilot that will test a redesigned approach to drafting final reports and the cover letters that accompany them. While a key focus of this work is to ensure that any data protection issues are addressed prior to publication, this project should also consider and address the points raised by the Independent Adviser, including the language around 'upholding' or 'not upholding' complaints.

There should also be an opportunity for complainants and bodies that are not directly involved in cases that are part of the pilot to comment on the new approach to report writing so that these views can be fed into the final redesign.

On a related matter, we also heard evidence that at present the final letters sent to complainants were not entirely clear about the role of the PHSO's Review and Feedback Team and how this can look again at the handling of a complaint within PHSO. We recommend that this specific wording is looked at more quickly than the wider work to improve PHSO's reports to make sure it is as clear as possible now.

Recommendation 8: A new system of data and information should be created

The Review Team agrees that there should be far greater transparency about where things have gone wrong, what recommendations have been made to remedy this and whether this has been accepted and completed.

As with the previous recommendation, we note that PHSO has already committed to publishing the vast majority of its casework online. We recommend that the system that is developed to deliver provides as much search functionality as possible. PHSO should also explore with LGSCO and other key system stakeholders how the data and information its system provides can best be integrated with their own information, whether that be in the form of mapping tools or other similar functionalities. Similarly, we hope it will be possible as part of the online system to develop sector or speciality specific 'newsletters' or other publications that share key learnings in a more focussed way with those working in the system.

In the interim, we also note that PHSO has already begun publishing quarterly data on the types of health cases it is receiving and has committed to expanding this data over time to include more information about the recommendations it has made and the level of compliance with these. Delivering this work should remain an organisational priority.

We are also aware that PHSO has recently introduced a process to improve the way it captures the risk profile of cases to progress them in the most appropriate manner. This risk profiling process should be reviewed to ensure that it adequately captures "severity of potential harm" as recommended by the Independent Adviser. This can then be used to inform the approach to investigation and to more easily identify cases with wider lessons for the NHS and system stakeholders. This work should take account of PHSOs typology of injustice and severity of injustice scale, recently published in guidance on financial remedy. It will also inform how it engages with the NHS wide 'emerging concerns' protocol that it has recently signed up to, to ensure that where there is evidence of critical care issues emerging, these are shared as quickly as possible across the system.

Recommendation 9: A Medical Director should be appointed to lead and oversee the new system of working

The Review Team agrees with the Independent Adviser that it will take some time to deliver the change that he has indicated is necessary. We also agree that, going forward, there will need to be clear day-to-day leadership for the clinical advice team.

Ultimately, a decision about the structure of PHSO's senior team is for the Ombudsman and Chief Executive to take in light of the requirements of the organisation and the budget that is available. In respect of the latter, we are conscious that over the current spending review period, PHSO has had to make savings of 24% and has recently conducted a review of its senior structure to reduce the number of senior posts across the organisation so it can live within the severe financial constraints placed upon it in the last Comprehensive Spending Review.

The Review Team do agree with the Independent Adviser, however, that ensuring the organisations 'clinical voice' is sufficiently strong at the most senior level is important. We note, for example, that its current lead clinicians are not involved in PHSO's 'Senior Leadership Team', which means they are not directly engaged in the discussions that

occur at this level. Whether or not there is specifically a 'Medical Director' or similar post created, as a minimum PHSO should make clear in its response to the Review about where in its senior structure the responsibility for clinical advice sits and how they are engaged in the organisations, leadership structure. This should include clarity about whether this same individual is responsible for overseeing implementation of the range of changes we have recommended or if this sits elsewhere.

Recommendation 10: A Director for Patients and Families should be appointed to develop a more complainant centred service

The Review Team agrees with Sir Liam that PHSO needs to continue to rebuild trust with complainants and their representatives, and that the culture of the organisation needs to be more attuned to patients' and families' experience of the NHS. As he also acknowledges, in its strategy PHSO has committed to, *"develop options for involving complainants in improving our service, to improve confidence and trust in our decision making"*.

This, together with the recommendations from the Independent Adviser and the Steering Group set out above, provides a strong focus on developing processes that meet the objectives underlying this recommendation. The aim is to embed the voice of patients and carers across all facets of PHSO's work. The Review Team has doubts whether a separate Director post is necessary, but recognises this is again a matter for the Ombudsman and Chief Executive to consider as part of their decisions around the structure of PHSO's senior team. Whatever is decided, however, it should be made clear in response to the Review what is being done to achieve the outcomes described, and where in the organisation responsibility for this sits.

Additional areas for consideration

There are some additional areas that were raised with us during consultation that are not fully addressed by the Independent Adviser's recommendations and our response to these as outlined above. Our Terms Of Reference also required the Review Team to look at issues including the short and long term options for procuring clinical advice and other related matters. We address these in this section.

Naming clinicians

We set out in response to Recommendation 2 from the Independent Adviser a range of actions that we propose should be taken to improve the quality of communication with complainants and the organisations being investigated throughout the lifetime of the case. In particular, we recommend that the qualifications and experience of the adviser and why they have been chosen are shared with the complainant.

An issue raised in the consultation was whether we should go further, and proactively name our clinical advisers as part of our casework process.

This is a finely balanced judgement – the rise of social media in particular means that the risks of inappropriate approaches to members of staff at all levels outside the workplace has increased in recent years. We are also conscious that some experienced advisers indicated to us during our consultation that they will leave the organisation if it is implemented given the impact it could have on their wider professional lives. Following implementation of the steps above, should the PHSO's Service Charter or other commensurate indicators demonstrate a significant improvement in complainants' view of its service in the relevant areas, it may indicate that the right balance in transparency has already been struck.

In particular, as the changes we have recommended are rolled out, we recommend PHSO tracks whether there are commensurate improvements in the response to the following questions in its survey of complainants:

- "We will share facts with you, and discuss with you what we are seeing"
- "We will explain our decision and recommendations, and how we reached them"

Should this not be the case, PHSO should commence a pilot to begin naming clinical advisers – although as indicated, we would not anticipate this commencing until towards the end of the current 3-year strategy to allow the other changes we have recommended to take effect and be assessed.

Any such pilot should proceed on the basis that it would not be proportionate for clinical advisers to be named in the final reports that PHSO plans to publish online as part of its new 3-year strategy. This could lead, for example, to advisers being approached about cases in which they have no involvement following simple internet searches highlighting their role at the organisation in similar cases. We therefore recommend that in any pilot, the names of advisers should only be shared in the cover letters provided to complainants and the bodies investigated at the final report stage.

In addition, there will need to be a clear and consistent message that all contact on a case should be directed through caseworkers, not through clinical advisers. As part of the pilot, PHSO should update its 'unacceptable behaviour' policy to make clear that attempts to directly contact clinical advisers would not be acceptable and could lead to action being taken up to, and including, making no further progression of the complaint. Clinical Advisers are not full time employees of the Ombudsman and usually have busy jobs in the NHS themselves treating patients that should not be impacted by their advisory role at the Ombudsman's office.

Prior to proceeding with any pilot, we also recommended that PHSO should engage with the relevant professional regulators to explore whether a special protocol could be established that provides greater assurance to clinical advisers about how any vexatious referrals will be dealt with. It is unclear whether anything appropriate would be achievable, but the feedback we received from advisers showed a clear appetite for an effort to be made in this regard. An update on whether anything has been practically achieved should be provided to all clinical advisers with an opportunity for them to highlight any further concerns before a pilot of naming them in cover letters is implemented.

Team structures

As part of the Review, in line with our Terms of Reference, we have also been considering the structure of PHSO's clinical advice team and whether this meets the needs of the changes we are proposing.

In addition to looking at PHSO's own data, we conducted a benchmarking exercise with other similar organisations, including other national ombudsmen from across the UK and some of the key medical regulators. The results of this work indicated that the way PHSO sources advice, using a core of internal advisers supplemented by commissioning external professional advisers as needed, remains appropriate. We have seen little evidence externally that a significantly different, more efficient model is available and as a result, we are not proposing major structural changes.

In waiting for the commencement and conclusion of this Review, however, PHSO's

clinical advice function has now begun to lag behind the structure of the wider office following the move of the majority of casework staff to Manchester. As a result, to optimise the current structure in line with the approach taken in respect of the wider organisations, we recommend that:

- Given the benefits that flow from face-to-face discussions between caseworkers and advisers, the recruitment of new internal advisers should be focused in PHSO's Manchester office – where the vast majority of casework staff are now based. Where, however, appropriately qualified clinical advisers could only be recruited in London, the full use of video-conferencing should be enabled.
- Casework demand forecasts, as recently developed by PHSO's Policy and Service Quality Team, should be used to inform future decisions on the number and types of advisers required.
- Service level agreements should be developed on expected times for requests to be allocated to advisers and the time it takes for final responses to be delivered to caseworkers. Given the recommendations we have made to share more information with complainants, it is important that caseworkers can communicate clear and realistic timescales on when this information is expected as part of their case handling.

The new clinical standard

Finally, as part of our consultation, we also sought views on the new Ombudsman's new clinical standard.

As indicated in the previous chapter while a small number of responses to the consultation challenged the fundamental content of the new standard and others made suggestions for improvement, there was also some significant positive feedback.

In respect of those challenges to the fundamental content, we are assured by the fact that the Ombudsman proactively sought independent Counsel's opinion on the approach he has taken to ensure it complies with recent court rulings. Given this expert input, we do not agree with the suggestion that it fails to achieve this aim.

More generally, we note that while the standard has only been in place a short period of time, anecdotally both caseworkers and some of the organisations investigated where it has been applied have indicated it has improved the quality of discussion and helped increase understanding of the Ombudsman's approach

We do understand the suggestions that were made to make certain elements of the standard read more accessibly. Ultimately, it is however crucial that it remains legally coherent and robust in light of recent judgements. Overall, we have therefore concluded that changes to the Standard at this time are not appropriate. We do agree that we can do more to make clear how the Standard is being applied in practice, which would support those organisations that advise organisations we investigate on such matters.

As a result, in advance of the Ombudsman publishing most of his casework, which will take some time to achieve, we recommend that once a sufficient sample of cases has been completed using the standard, a series of case studies should be produced to help bodies like the MDU to support and advise their members more effectively. This product would also be useful for others, such as complaint handlers, contributing to the Ombudsman's wider strategic objective to improve frontline complaint handling.

Delivering change

The recommendations made by the Independent Adviser and our response to these would introduce significant changes to how clinical advice is used in the casework process going forward. These changes are important. As noted at the outset of this chapter, it is also crucial that they are introduced carefully so that they do not disrupt the delivery of current casework or introduce unnecessary delays that undermine the experience of both current complainants and the organisations that are being investigated. This would be contrary to what we are trying to achieve.

We have identified a number of improvements that could be made to PHSO's overall processes and procedures that would improve the approach to requesting and using clinical advice. These would give practical effect to many of the recommendations made by the Independent Adviser and address many of the comments we saw during consultation. It is also important, that before these are implemented, the impact they may have on existing work is assessed alongside the wider changes that the Ombudsman has committed to delivering in his three-year strategy, such as introducing different methods of dispute resolution and changing the approach to writing final reports in advance of publishing these online.

It is not possible for the Review Team to conduct such an assessment in isolation, as the time needed to train staff, draft new processes and oversee the change that is needed should be looked at alongside other service improvements that PHSO is seeking to deliver.

As we have indicated throughout this chapter, it would seem sensible to pilot some of the changes we have recommended. This would enable PHSO to fully understand their impact and to identify ways that further improvements can be made in light of the practical experience of caseworkers, advisers, complainants and organisations being investigated.

Appendix 1

Terms of Reference for Clinical Advice Review

The Parliamentary and Health Service Ombudsman has asked Sir Alex Allan, a non-executive director of PHSO, to oversee a comprehensive review of the use of clinical advice in the Ombudsman's case work to ensure that the system used is consistent with the new organisational values of independence, fairness, excellence and transparency.

The review overseen by a steering group chaired by Sir Alex will examine the options for, and make recommendations to, the Ombudsman and Chief Executive about:

what process the Ombudsman should use for incorporating clinical advice into casework decisions, including how advice is commissioned and utilised in decision making through to how the function itself is staffed and supported;

- the level of detail that reports communicating any Ombudsman decisions informed by clinical advice should provide about that advice;
- the short and long term options for obtaining clinical advice and the support, staffing and financial implications of each option;
- what, if any, additional training is needed for clinical advisers and/or the caseworkers commissioning advice to help ensure it is correctly formulated to inform lay decisions under the process recommended; and
- any other improvements that could be made to PHSO's overall clinical advice process in line with its values.

To inform development of the clinical advice process, the Review will initially prepare proposals for consultation with PHSO staff and stakeholders, so that their views can be incorporated into the final recommendations of the Review.

Sir Liam Donaldson has been appointed as the Independent Adviser to the Review. In his role advising Sir Alex and the Steering Group, Sir Liam will:

- develop and recommend a set of core principles for the types of cases where PHSO should seek clinical advice to incorporate into its process, including reference to the balance between where more general and specialist advice is needed and how decisions involving clinical advice can be devised to have the best impact;
- review the current quality of clinical advice used in Ombudsman decisions and make recommendations on any ways to improve this;
- set out how clinical advice received by PHSO should be balanced with other evidence received from complainants and relevant organisations we investigate;
- give advice to the Steering Group on the different models of delivery that may be available; and
- make recommendations in respect of the training needs of advisers and caseworkers to optimise the benefits of clinical advice.

In each area, Sir Liam will present proposals for discussion at the Steering Group, before then confirming his final recommendations. At the conclusion of the Review, Sir Liam will then also provide written assurance directly to the Ombudsman and Chief Executive that the final approach outlined by the Steering Group is compliant with the principles he has recommended.

The Review will aim to share its final recommendations with the Ombudsman and Chief Executive by the end of 2018. It will also ensure that the final recommended process is prepared in such a way so that, once signed off by the Ombudsman and Chief Executive it, as well as the principles and standards prepared by the Independent Adviser, can be published online.

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