



Our response to the Clinical Advice Review

Contents

Foreword	3
The Clinical Advice Review	5
Implementing the Review's recommendations	
Greater integration of clinical advisers into the casework process	5
Effective and consistent communication with all those involved in a complaint	8
Balancing evidence and ensuring everyone understands how it is used to reach decisions.	12
Applying the appropriate range of methods when investigating the causes of poor care and sharing learning	15
Staffing	18

Foreword

PHSO has a unique role to play as 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. This means that there must be trust and confidence in the Ombudsman if we are to provide an effective resolution to the complaints brought to us. Decisions must be demonstrably impartial, fair and informed by a thorough and competent consideration of the relevant evidence.

Clinical advice is a key aspect of our NHS-related casework process. We use it as a vital source of evidence to inform our thinking in around three-quarters of our health investigations. So it is crucial that PHSO commissions and uses it appropriately and that those involved in a complaint understand and have confidence in the way it has informed our decisions.

I established a comprehensive review of how PHSO draws upon clinical advice for resolving complaints to ensure it is in line with our values of independence, transparency, fairness and excellence. We must embed these values in everything we do in order to meet the ambition set out in our 3-year strategy to become an exemplary Ombudsman service.

I am very grateful to Sir Alex Allan for chairing the Review, to Sir Liam Donaldson for his work providing independent advice to it and to the rest of the Review Team for helping craft a challenging but vital set of recommendations. I also want to thank all those who engaged in the Review's consultation process, providing Sir Liam, Sir Alex and the rest of the team with the unvarnished insight they needed to develop these recommendations.

PHSO is accepting the vast majority of the recommendations made by Sir Liam in his role as Independent Adviser, and Sir Alex's Review, as a whole. The Review's recommendations show us how to improve assurances to all involved in a complaint that we have commissioned, used and reported clinical advice appropriately.

Some of the recommended changes are significant in that they include greater interaction between clinical advisers and caseworkers, and more frequent communication with complainants.

The Review makes clear these changes will have a significant cost impact on the delivery of PHSO's service and will require changes to process, internal guidance and staff training.

It is important that we implement the recommendations speedily and in a structured way that complements other aspects of our transformation. We have undertaken considerable planning to ensure that our approach to implementing the Review is deliverable alongside our wider business plan, which is carefully phased across 2019/20 and 2020/21 to take us to the end of our 3-year strategy. As we will make clear in our business plan, this approach includes a need for flexibility across the next two years. We will use the in-year learning we generate from implementing the significant changes we have planned to help us deliver activity more quickly where possible, or move it back where this is needed, including in relation to the plans set out in this response.

I am confident that by the end of our current 3-year strategy the implemented recommendations will further enhance the quality, fairness and transparency of our decisions on complaints that require clinical advice.

Rob Behrens, CBE
Ombudsman and Chair
Parliamentary and Health Service Ombudsman

The Clinical Advice Review

In summer 2018, fulfilling a commitment made in PHSO's new 3-year strategy we established a Review Team looking at the use of clinical advice in the Ombudsman's casework, and in particular in those cases where advice from an independent clinician has been sought.

The Review Team was chaired by Sir Alex Allan and its membership included Dr 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 and currently the World Health Organisation's Envoy for Patient Safety was commissioned to act as an Independent Adviser to the Review.

The Review Team issued a consultation paper in September 2018, asking for feedback on the principles that underpin the Ombudsman's use of clinical advice, the quality and comprehensiveness of the clinical content of PHSO's reports, 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. We also published a background paper with detailed information on our current clinical advice process. We have not repeated this information here but this is available on our website: www.ombudsman.org.uk.

In line with our commitment to transparency, we have also published the Review Team and Independent Adviser's full final reports on our website. The Review Team's report includes a detailed summary of findings from the consultation, its response to each of the Independent Adviser's recommendations and additional recommendations from the Review Team's own detailed analysis. The Independent Adviser has also provided written assurance to the Ombudsman that the Review's final report is in line with the key elements of his proposals.

This Response sets out our high level summary of the Review's recommendations, related findings and what we will now do to implement the change that is needed. For ease of reference, we have clustered the Review's recommendations under five core themes:

-  Greater integration of clinical advisers into the casework process
-  Effective and consistent communication with those involved in a complaint
-  Balancing evidence and ensuring everyone understands how we have used it to reach decisions
-  Applying the appropriate range of methods to investigate the causes of poor care, and share learning
-  Staffing

Implementing the Review's recommendations



Greater integration of
clinical advisers into the
casework process

Recommendations

Sir Liam proposed that:

- clinical advisers should be much better integrated into casework, including agreeing how their advice is used in provisional views and final reports;
- clinical advisers should be encouraged to identify any serious problems in care even if it is not an area covered by the complaint.

The Review fully supported these principles and recommended that PHSO:

- **explore increased involvement of Clinical Adviser's at key stages of the casework process while maintaining professional, caseworker led decision making and timely casework outcomes;**
- **ensure that clinical advisers consistently receive all relevant background case material and that there is greater clarity on how they identify serious problems that are not directly in scope;**
- **enable continuous learning and improvement between caseworkers and clinical advisers.**



Findings

Under our current process, clinical advisers primarily respond to questions from caseworkers when a complaint has been accepted for investigation. They are not routinely involved at other stages of our process, including when complaints are assessed and when their advice is incorporated into provisional views and final reports.

Sir Liam found the effectiveness of our current process for commissioning and using advice varied depending on the caseworker's level of understanding and clinicians access to information. Where these were limited or partial, he judged that the relatively limited level of interaction between caseworkers and advisers made the PHSO process vulnerable to errors of fact, interpretation and omission.

The Review also heard from some complainants that they felt that the clinical advice cited in PHSO's reports did not address the substance of their complaint or omitted key aspects of it. This undermined their trust and confidence in our process, leading some to question whether we used the appropriate adviser and/or whether caseworkers asked the right questions.

The Review also identified some inconsistent practice across the organisation. Some advisers noted that they would only provide advice on the questions they were asked, whereas 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. Sometimes they just received the key clinical records, but at other times they would also receive the original complaint and organisational response as additional background.

Our response

In 2019/20 we will:

- Issue new guidance for caseworkers on the information they should provide to clinical advisers when requesting advice.
- Issue clearer guidance for clinical advisers on how they can raise issues outside of the caseworker's questions they have received; including where they identify serious failings that are outside the scope of the complaint.
- Introduce surveys for clinical advisers to comment on the quality of requests from caseworkers and for caseworkers to comment on the quality of clinical advisers' responses.
- Develop and, if possible due to wider business plan activity, launch pilots to test the benefits, costs and understand the impact on resources and current case handling times of:
 - sharing provisional views with clinical advisers
 - sharing clinical advice in advance of provisional views with complainants and bodies in remit
 - convening multidisciplinary meetings with advisers and others (for example, legal colleagues) once specialist advice has been received

- Develop evaluation and lessons learned exercises for pilots to inform the approach to full implementation.

In 2020/21 we will:

- Launch any pilots not commenced in 2019/20 due to wider business plan pressures and develop a further pilot to test the benefits, cost and understand impacts on case handling times of increased involvement of clinical advisers at our assessment stage.
- Develop evaluation and lessons learned exercises for the pilots to inform the approach to full implementation.



Implementing the Review's recommendations



Effective and consistent communication with all those involved in a complaint

Recommendations

Sir Liam proposed that:

- there should be greater contact and better communication with complainants, including: sharing the qualifications and speciality of the clinical advisers proposed and asking complainants to comment on requests for clinical advice and the subsequent advice before it is adopted;
- the tone and content of final reports and letters conveying decisions to complainants should be improved to ensure sensitivity.

The Review strongly agreed that effective and consistent communication, particularly with complainants, throughout the lifetime of a case is essential for ensuring trust and confidence in the Ombudsman process.

The Review gave careful consideration to whether this should include sharing the names of clinical advisers. On the one hand, this is in line with our commitment to transparency and would enable complainants and bodies in remit to assure themselves about the independence and suitability of clinical advisers. On the other, the Review felt we do not yet have the right processes in place to deal with the concerns raised by clinical advisers about potential harassment and vexatious

referrals to professional regulators. Moreover, the Review concluded that the anonymity of advisers was only one of a series of factors affecting trust and confidence in our process. They felt that it was important that we evaluate the impact of implementing the Review's other recommendations before making a final decision on publicly naming clinical advisers.

The Review recommended that PHSO:

- **provide more information to those involved in a complaint about the clinical advice process across the lifetime of a case, including sharing clinical advice before sharing provisional views;**
- **engage with professional regulators, before proceeding with any plans to name advisers, to explore whether a protocol can be established to provide assurances about how any vexatious referrals of advisers will be dealt with;**
- **evaluate the impact of the Review's changes on trust in the Ombudsman process to inform any subsequent decision to share the names of advisers with those involved in a complaint;**
- **review the language used to describe its decisions and findings to ensure they have appropriate sensitivity.**



Findings

The Review heard from complainants that they expected greater visibility of what is happening at the point that clinical advice is requested and greater opportunities to input views before clinical advice is incorporated into provisional views. The majority wanted more information about clinical advisers, to be assured of both their competency and independence. Some felt the names of clinicians should be shared to provide this assurance, whereas others thought sharing qualifications and experience was sufficient. More generally, people felt frustrated about the lack of information they received about the progress of their case.

Although our existing Service Model prompts caseworkers to involve and update complainants on the progress of their case, the Review found this was not done consistently and that there are gaps with respect to the clinical advice process.

Several clinical advisers told the Review that they had strong concerns about potential harassment and vexatious referrals to regulators if their names were shared with those involved in a complaint. Some said that they would be reluctant to continue at PHSO if we moved to routinely naming advisers in reports.

Sir Liam also noted that;

introducing a policy to name clinical advisers could have unintended negative consequences even though it would fit with the PHSO's commitment to transparency.



Our response

In 2019/20 we will:

- Produce new information for complainants at the outset of an investigation explaining the role of clinical advice, how it is used and how complainants and organisations we investigate will be involved in this part of our process.
- This information will be updated to include changes to our processes to reflect the recommendations of the Review so that we consistently:
 - inform complainants and organisations when clinical advice has been requested;
 - tell both sides of the complaint proactively about the qualifications and experience of the clinical adviser and why they were chosen;
 - Share the clinical advice received with those involved in a complaint before our provisional views on the case are issued.
- review the language we use to communicate the outcome of our investigations and pilot how this is presented in our final reports as part of the work we are developing to publish the vast majority of our casework online by the end of our current 3-year strategy.

- engage with professional regulators to explore whether a protocol can be established to provide assurances about how any vexatious referrals of advisers will be dealt with, should we proceed with proactively naming them.

In 2020/21 we will:

- Evaluate the impact of implementing the Review's recommendations on trust in our process and related Service Charter scores.
- Following our discussions with professional regulators, develop a pilot to begin naming clinicians.
- Begin publishing the vast majority of our casework online and using new language to communicate the outcome of our investigations in all of our final published reports.



Implementing the Review's recommendations



Balancing evidence and ensuring everyone understands how we use it to reach decisions.

Recommendations

The Independent Adviser proposed that:

- PHSO should ensure appropriate emphasis and weight is given to the opinions of patients and family members on clinical events.

The Review fully supports this principle and recommends that PHSO:

- **provide additional support to caseworkers in assessing the balance of evidence received from complainants and organisations we investigate, including where an organisations clinical records are missing/partial and how this should inform decision making.**

The Review received assurance from a number of consultees that the Ombudsman’s new Clinical Standard was sufficiently clear but some suggested that further examples of how it is being applied in our casework would be useful for organisations we investigate. The Review recommended PHSO:

- **produce a series of case studies, once a sufficient sample of cases has been completed using the Standard, to support organisations we investigate to understand how PHSOs using it.**



Findings

The Review heard from a number of complainants that they felt their evidence and testimony were given less weight than the organisations complained about and that they felt ‘disbelieved by default’. Caseworkers noted that it could be difficult to weigh evidence from both sides: organisations being investigated often have more written evidence than the complainant, who at times has their personal testimony alone. The Review was clear that contemporaneous clinical records are often an essential element of the evidence informing our decision. However, they heard that we could be clearer on how these are balanced against personal recollection and how the balance might shift in cases where such clinical evidence is missing or disputed.

The Review also consulted on the Ombudsman’s new Clinical Standard, which sets out how he decides whether or not there have been failings in clinical judgement and the range of evidence considered when making this decision. The Review heard some concerns from medical defence organisations that the Clinical Standard set the bar too high in looking at “good” rather than “reasonable” care and that it was not clear how this would be applied in practice. However, it also heard positive feedback from some medical professionals and patient organisations as to its clarity.

Our response

In 2019/20 we will:

- Produce new caseworker guidance on assessing the balance of evidence, make this available online and include it in the information provided to complainants at the outset of their case.
- Adapt our training programme to incorporate this guidance.
- Publish case studies on how PHSO is applying the Clinical Standard to allow the organisations we investigate and others to understand how it is used in practice.



Implementing the Review's recommendations



Applying the appropriate range of methods when investigating the causes of poor care, and sharing learning

Recommendations

Sir Liam felt that PHSO’s current approach to investigation placed too much emphasis on the culpability of individual clinicians. He proposed:

- The organisation should take a systems-based approach to investigations and caseworkers, should be trained in alternative investigative approaches such as human factors analysis.

The Independent Adviser also recommended that a new system of data and information should be created to enable PHSO to more easily identify serious cases and share learning on a more regular basis with NHS services. He noted that a “severity of potential harm” classification for all incoming complaints would also enable a more effective tailoring of investigative approaches.

The Review agreed that PHSO could do more to ensure consistent consideration of the full range of relevant factors when investigating clinical failings. It also agreed 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. The Review recommended that PHSO:

- assess the benefits of supplementing its current investigative methods with additional approaches, learn from the work of other Ombuds and Regulators and identify options that could be built into PHSO’s service;
- ensure the matters highlighted by the Independent Adviser are given full consideration in PHSO’s existing work on risk profiling of cases and planned work to meet its strategic commitment to greater transparency.

Findings

The Review heard some concerns from both complainants and organisations in remit that inadequate consideration is given to wider potential evidence, including human and social factors, to balance against clinical factors when considering failures in care and treatment. This led some to question whether PHSO effectively identifies and escalates systemic issues.



Our response

In 2019/20 we will:

- Review our risk profiling process to ensure it effectively captures “severity of potential harm”.
- Based on this Review, identify any further activity that is needed to make sure we are both identifying appropriate insight to share with parliamentarians and policy makers and meeting the obligations around patient safety issues to which we are committed through our membership of the Emerging Concerns Protocol (this provides a mechanism for PHSO to share information and intelligence on potential risks to service users with health and social care regulators).
- Begin work to engage with professional regulators and other Ombuds to identify additional approaches to investigation we might incorporate into our service and develop options for how we might achieve this.

In 2020/21 we will:

- Set out any new approaches to investigation we decide to introduce into our service and how we plan to deliver these as part of our next corporate strategy.



Implementing the Review's recommendations



Staffing

Recommendations

Sir Liam was clear that achieving the changes necessary to address the findings of the Clinical Advice Review would be a developmental process, requiring strong leadership, cultural change and the embedding of new behaviours. To enable this, he recommended creating two new senior posts in our structure:

- a Medical Director to lead and oversee the development of the new system of working;
- a Director for Patients and Families to develop a more complainant centred service..

The Review Team agreed that these changes would take time and needed to be underpinned by new cultural norms and behaviours. The Review noted that decisions about the structure of our senior team are for the Ombudsman and Chief Executive to take in light of the requirements of the organisation and the budget that is available. With respect to the Medical Director post, the Review said PHSO should provide clarity about who has responsibility for the Clinical Advice function in its senior structure and if this includes overseeing the changes recommended by the Review.

The Review Team agreed with the Independent Adviser that the culture of the organisation needs to be more attuned to patients and families experience. It noted that we have committed in our strategy to “develop options for involving complainants in improving our service, to improve trust and confidence in our decision making”. However the Review Team was not convinced that creating a separate director post is necessary or appropriate, as the aim is to embed the voices of patients and carers across all facets of our work.

Our response

As part of our approach to delivering the 24% cuts required of PHSO in the last Spending Review, PHSO has significantly reduced the senior team to streamline the management structure and to help protect frontline staff. This remains a priority and we do not currently have the resources to introduce the new posts proposed at such a senior level. However, as part of the implementation of the Review’s recommendations, we will give full consideration to any changes that may be needed to the structure and leadership of the clinical advice team as we develop our next Comprehensive Spending Review bid.

We are also confident, however, that our now well-established senior team is capable of implementing the recommendations of the Review without the need for a specific Medical Director to support this. Our Clinical Advice team is already managed by three experienced clinicians. Since Sir Liam started his work, the mix of backgrounds we have in these roles has also changed from three nursing practitioners to a spread across the most common generalist areas where we require advice (emergency medicine, general practice and nursing).

We agree that clarity is needed about who will be overseeing this work at a senior level. We can confirm that our Director of Operations will be leading the project to implement the activity outlined in this response, while our existing clinical leads and other senior staff will also be closely involved to support the significant changes recommended by the Review. We will also be exploring the creation of an expert advisory panel with a mix of clinicians, patient safety experts and others to use in our work as appropriate in the future.

In respect of a ‘Director for Patients and Families’ it also important that all of our senior team have

an understanding of the needs of our service users from across public and health service organisations. To maintain our impartiality, it is also important to take account of the views of the organisations we investigate. We therefore agree with the Review that, even ignoring the lack of budget for such a post, it would not necessarily be the most effective way of achieving greater confidence in our service.

We do agree, as set out in our 3-year strategy, that PHSO should 'develop options for involving complainants in improving our service, to improve confidence and trust in our decision making'. Meeting this commitment goes well beyond the remit of the Clinical Advice Review and we will share our plans on involving complainants in the coming months.

In 2019/20 we will:

- Make clear in our published business plan where ownership for implementing the clinical advice review sits in the organisation.
- Explore the creation of an 'expert advisory panel' with a mix of clinicians, patient safety experts and those from other backgrounds that we can use in our work as appropriate.



Parliamentary and Health Service Ombudsman

Citygate
Mosley Street
Manchester
M2 3HQ
United Kingdom

Telephone: 0345 015 4033

Textphone: 0300 061 4298

Fax: 0300 061 4000

Email: phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

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