From: Mansfeld Maria
Sent: 13 September 2017 11:40
To: 'Bruce Newsome'
Subject: RE: RE: RE: Blog by Bruce Newsome

Dear Bruce,

Apologies for the delay in getting back to you.

My email to the Editor was seeking to clarify a few points in your blog post for discussion; it wasn't intended for publication.

Kind regards
Maria

From: Bruce Newsome [redacted]
Sent: 12 September 2017 06:28
To: Mansfeld Maria
Subject: Re: RE: RE: Blog by Bruce Newsome

Maria -

A week has passed since I emailed you. If I don't hear from you by the end of the week I will assume that you don't care whether our correspondence is published, which is not marked private or confidential.

Bruce Newsome, Ph.D.
Evidence-based knowledge and practical skills
"No assumption too sacrosanct"

From: Bruce Newsome [redacted]
To: [redacted]
Sent: Tuesday, September 5, 2017 11:01 AM
Subject: Re: RE: RE: Blog by Bruce Newsome

Maria -

Since you are keen to write a blog too, would you permit publication of our correspondence?

Bruce

Bruce Newsome, Ph.D.
Evidence-based knowledge and practical skills
"No assumption too sacrosanct"

From: Paul goodman [redacted]
To: [redacted]
Cc: [redacted]
Sent: Sunday, September 3, 2017 7:01 PM
Subject: Re: RE: RE: Blog by Bruce Newsome

Maria -

Rightly or wrongly, I think that my role in responding to complaints about articles is to act any reasonable complaint of gross unfairness.

I understand that the PHSO wants to protect its position - and unlike some of those who don't agree with pieces published on our site, or elsewhere, has the capacity and resources to do so.

But having read the correspondence to and fro, I have to say that, with the exception of the point about accountability, I don't think your points prove that Bruce Newsome has been grossly unfair: indeed, many don't contradict the matters he raises - a good example being his reference to the percentage of cases that the PHSO investigates. His figure isn't challenged, and in my view it is anyway the percentage that matters, not the total.

I am copying this e-mail to Mr Newsome.

Paul

----Original message----
From : [redacted]
Date : 29/08/2017 - 09:37 (BST)
To : [redacted]
Subject : RE: RE: Blog by Bruce Newsome

Hi Paul

Apologies for the delayed response – I was out of the office last week.

Thank you for forwarding Mr Newsome's response. While I disagree with his points I accept that he won't consider making any changes.

Perhaps we could write a blog for Conservative Home sometime in the future instead, covering some of the points we were trying to make?

Kind regards
Maria

From: Paul goodman [redacted]
Sent: 20 August 2017 09:16
To: Mansfeld Maria
Subject: Fwd: RE: Blog by Bruce Newsome

Maria -

Here is Bruce Newsome's response to your points.

Paul

- - -

'The ultimate authority for complaints against health and social care is the misleadingly titled Parliamentary & Health Service Ombudsman (PHSO), which is neither accountable to Parliament, nor responsible for any particular health or care service. No parliamentary committee or politician can overrule it. The PASC can only examine its reports.'

- Contrary to the claim in the blog post, we *are* accountable to Parliament and our work is scrutinised by the Public Administration and Constitutional Affairs Committee.

THIS IS SPIN: THE PHSO USES THE TERM "SCRUTINIZED", IN REPLACEMENT OF MY TERM "EXAMINE", THEN THE PHSO UNJUSTIFIABLY CLAIMS THAT "WE ARE ACCOUNTABLE" TO THE PASC - NO, THIS IS NOT ACCOUNTABILITY. MY FACT STANDS: THE PHSO'S REPORTS CAN BE EXAMINED BY THE PASC BUT CANNOT BE OVERRULED; NOBODY AT PARLIAMENT OR GOVERNMENT CAN ORDER THE PHSO TO INVESTIGATE ANYTHING, CORRECT ANYTHING, FIRE ANYBODY, CHANGE ITS STRUCTURE, CHANGE ITS PROCESSES, OR ANYTHING ELSE THAT WOULD COUNT AS AUTHORITY OVER THE PHSO. IT IS FUNDED FROM PUBLIC MONEY, BUT IS NOT PUBLICLY ACCOUNTABLE, EXCEPT TO BAD PRESS

- We were set up by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS in England and UK government departments. We are not part of government or the NHS in England. We are neither a regulator nor a consumer champion.

I AGREE, AND THIS IRONICALLY PROVES MY POINT. THE PHSO IS NEITHER A REGULATOR NOR A CONSUMER CHAMPION, THUS IT IS USELESS FOR THE VASE MAJORITY OF COMPLAINANTS

'As you would expect, the PHSO's unaccountability encourages the PHSO's irresponsibility. The PHSO usually refers complainants back to any of those 70-odd other organizations, until the complainants exhaust whatever complaints system exists at the organisational level – or (more commonly) the complainant gives up on a costly, confusing, and unrewarding system.'

• We are the last port of call for complaints that have not been resolved by the NHS in England and UK government departments. We investigate complaints fairly, robustly and without taking sides.

SPIN - CONTRADICTED BY THE HISTORY OF FRUSTRATED COMPLAINANTS WHO RECEIVE NO INVESTIGATION AT ALL. THE ONLY PART I AGREE WITH IS, YES, THE PHSO IS THE "LAST PORT OF CALL"! THAT'S WHY THE PHSO'S FAILURES ARE SO FRUSTRATING FOR HUNDREDS OF THOUSANDS OF BRITONS.

I CHOSE NOT TO MENTION IN THE ARTICLE (IN ORDER TO AVOID BRINGING FURTHER PAIN TO THE FAMILY) THE TRAGIC CASE OF SAM MORRISH, THE TODDLER WHO DIED IN 2010 DUE TO MALPRACTICE; THE PHSO REFUSED AND MISHANDLED HIS PARENTS' COMPLAINTS UNTIL FINALLY REACHING A JUDGMENT IN 2014, WHICH WAS FULL OF FACTUAL ERRORS - THE REPORTING DRAGGED ON INTO 2016 - SCOTT MORRISH IS STILL CAMPAIGNING FOR CHANGE - HOW WAS THE PHSO "FAIR AND ROBUST" IN THAT CASE?

THE PUBLIC MAKES HUNDREDS OF THOUSANDS OF COMPLAINTS AGAINST HEALTH AND SOCIAL CARE PER YEAR; THE PHSO INVESTIGATES JUST A FEW THOUSAND PER YEAR; THE OVERWHELMING EXPERIENCE FOR COMPLAINANTS IS DISSATISFACTION. I COULD HAVE INCLUDED IN THE ARTICLE THE ORGANIZATIONS SET UP BY DISSATISFIED COMPLAINANTS SPECIFICALLY TO LOBBY AGAINST THE PHSO, SUCH AS "PHSO THE FACTS" (http://phsothefacts.com/ - I DID NOT INCLUDE THEM BECAUSE I DID NOT WANT TO APPEAR TO REPRESENT THEM, AND I DON'T REPRESENT THEM; I SPEAK AS AN EXPERT ON RISK MANAGEMENT: AS I SAID IN THE ARTICLE, UNACCOUNTABLE SYSTEMS ARE RISKIER SYSTEMS.

• The Health Service Commissioners Act sets outs the conditions under which we can accept complaints about the NHS. The law prevents us from conducting an investigation unless we are satisfied the NHS complaints process has been used and exhausted, or it was not reasonable to expect the complainant to have done so. It essential that NHS organisations have an had opportunity to resolve the issue locally before people bring a complaint to us.

THIS RULE IS OPEN TO INTERPRETATION AND THENCE ABUSE - THE PHSO INVESTIGATES A TINY FRACTION OF COMPLAINTS RECEIVED; ITS INFERENCE HERE IS THAT ALL OTHER COMPLAINTS ARE IMPROPER, AND MUST BE BOUNCED BACK TO SOME OTHER AUTHORITY, BUT THAT IS NOT MOST COMPLAINANTS' EXPERIENCE - THE PHSO AND THE OTHER 70-ODD AUTHORITIES ARE ENGAGED IN A MERRY-GO-ROUND OF PASSING THE BUCK BETWEEN THEM, FINDING FAULT WITH COMPLAINTS, LOSING

CORRESPONDENCE, DELAYING CORRESPONDENCE, REASSIGNING CASE OFFICERS - OR DECLARING THAT SOME OTHER AUTHORITY HAS RESPONSIBILITY FOR IT - UNTIL MOST COMPLAINANTS GIVE UP. YES, THE OTHER ORGANIZATIONS SHOULD BE GIVEN FAIR CHANCE TO RESPOND, BUT THE PHSO EXPECTS US TO BELIEVE THAT AROUND 95% OF COMPLAINANTS TO THE PHSO HAD FAILED TO GIVE THE PERTINENT ORGANIZATION CHANCE TO RESPOND. THIS WOULD SEEM AN EXCESSIVE PROPORTION, EVEN IF I HAD NOT SEEN ALL THE EVIDENCE FROM PHSO-THE-FACTS AND ELSEWHERE OF DELIBERATE FRUSTRATION OF LEGITIMATE COMPLAINTS.

- We publish detailed information on our website clearly explaining our role and how we work as well as investigation summaries which set out what our investigations have achieved.

SPIN, CONTRADICTION, AND IRONICALLY PROVES MY POINT: AS I WROTE IN THE ARTICLE, THE PASC HAS ADMITTED THAT THE SYSTEM IS CONFUSING - THE PHSO CONTRADICTS ITSELF ROUTINELY BY ADMITTING THAT IT RECEIVES HUNDREDS OF THOUSANDS OF COMPLAINTS WHILE CLAIMING THAT ALMOST ALL OF THESE COMPLAINTS SHOULD HAVE BEEN DIRECTED ELSEHWERE; THEN WHY ARE COMPLAINANTS SO CONFUSED AS TO COMPLAIN TO THE PHSO? A CONFUSING AND IRRESPONSIBLE SYSTEM CANNOT BE FIXED BY A WEBSITE - IT MUST BE RESTRUCTURED.

‘The PHSO traditionally has investigated only one per cent of complaints – as if 99 per cent of complainants had the time and motivation to complain unnecessarily. In 2013, Mellor suddenly promised a ten-fold rise in the number of PHSO investigations, but 10 per cent is as arbitrary as one per cent. The PHSO actually investigated less than eight per cent in the subsequent fiscal year, or merely 2,199 complaints; the NHS alone received 175,000 complaints that year.’

- In 2016-17, we considered over 30,000 complaints and fully investigated more than 4,000 cases. Where we can, we will seek to resolve complaints and provide complainants with answers sooner, without the need for a full investigation.

OH! THE DEFT HANDLING OF STATISTICS! NOTE THAT NO TOTAL IS GIVEN FOR ALL COMPLAINTS RECEIVED - IN FACT, 120,000 WERE RECEIVED THAT YEAR, OF WHICH 25% WERE "CONSIDERED", WHICH DOES NOT MEAN INVESTIGATION, IT MEANS LIMBO BETWEEN OUTRIGHT REJECTION AND INVESTIGATION. WHAT IS AVERAGE PERIOD AND MEDIAN PERIOD BETWEEN A COMPLAINT RECEIVED AND HELD IN CONSIDERATION, LET ALONE RESOLVED? ANECDOTAL EVIDENCE SUGGESTS MORE THAN A YEAR, BUT THE PHSO PROVIDES NO DATA FOR ITSELF.

NOTE THAT NO PROPORTION/RATE IS GIVEN FOR THE NUMBER OF CASES INVESTIGATED AS A PROPORTION/RATE OF ALL COMPLAINTS RECEIVED! THE PHSO WAS INVESTIGATING 3% OF COMPLAINTS RECEIVED IN 2016-17! THAT'S A SMALLER PROPORTION THAN IN 2013!

NOTE ALSO THAT THE PHSO HAS NOT RESPONDED TO MY MAIN POINT THAT THE RATE OF INVESTIGATION IS ARBITRARY: IN 2013, JULIE MELLOR SAID SHE WOULD INVESTIGATE 10% RATHER THAN 1% - WHY SET A RATE? WHAT IS THE CORRECT RATE? WHY WAS IT 1% BEFORE 2013, THEN PROMISED AT 10% IN 2013, BUT ACTUALLY 8% IN THE SUBSEQUENT YEAR? WHY WAS IT 3% IN THE MOST RECENT YEAR? THESE RATES ARE ARBITRARY, UNEXPLAINED, AND UNACCOUNTABLE. THE PHSO SHOULD BE INVESTIGATING ANY PROPER COMPLAINT - THE PUBLIC OVERWHELMINGLY SAY THAT THE PHSO FRUSTRATES PROPER COMPLAINTS. WITHOUT ACCOUNTABILITY, THE PUBLIC HAS NO WAY TO KNOW WHETHER THE PHSO IS INVESTIGATING THE PROPER PROPORTION OF ALL COMPLAINTS RECEIVED.

- Of the 30,000 complaints we handled in 2016-17, three quarters weren’t ready for us to look into. When people bring complaints that aren’t ready for us, we give them advice on how best to progress their complaint.

THIS IS SUBJECTIVE AND UNACCOUNTABLE - SINCE THE PHSO IS UNACCOUNTABLE, NOBODY CAN EXAMINE HOW THE PHSO DECIDES WHEN IT BOUNCES A COMPLAINT BACK TO THE COMPLAINANT; THUS NOBODY BUT THE PHSO DECIDES WHAT IS A PROPER COMPLAINT; THUS EACH JUDGMENT IS AN UNACCOUNTABLE JUDGMENT

THE PHSO'S CONCLUSION THAT "WE GIVE THEM ADVICE ON HOW BEST TO PROGRESS THEIR COMPLAINT" IS RICH - AS I WROTE IN THE ARTICLE, IT TELLS ALMOST ALL COMPLAINANTS TO EXHAUST WHATEVER COMPLAINTS SYSTEM EXISTS AT ANY OF THE 70-ODD OTHER AUTHORITIES, EVEN IF THE COMPLAINANT IS COMPLAINING ABOUT BEING FRUSTRATED BY THOSE OTHER AUTHORITIES; THE PHSO DOES NOT WORK WITH COMPLAINANTS TO REACH RESOLUTION, IT DOES NOT CHAMPION THE COMPLAINANT'S COMPLAINT AGAINST ANY OTHER AUTHORITY, IT JUST TELLS THE COMPLAINT TO GO ELSEWHERE - THIS DOES NOT COUNT AS "ADVICE ON HOW BEST TO PROGRESS THEIR COMPLAINT"

‘The PHSO routinely fails to acknowledge complaints, claims that complaints are incomplete or improper, misaddresses responses, or reduces or reinterprets complaints. The complainant has no right of appeal against the PHSO. The PHSO dedicates no case officer to a complaint – thus, complainants are forced to deal with a different correspondent with almost every reply’

- We handled over 120,000 enquiries in 2016-17, helping direct complainants to where their complaint could be most quickly resolved.

REPETITIVE SPIN AND INCREMENTALISM: TELLING ALMOST ALL COMPLAINANTS THAT THEIR COMPLAINT IS IMPROPER, WITHOUT CHAMPIONING THEIR COMPLAINT TO THE RESPONSIBLE RECIPIENT, WHICH IS OFTEN THE SUBJECT OF COMPLAINT, IS NOT "HELPING" COMPLAINANTS, IT IS FRUSTRATING THEM

- We investigate unresolved complaints fairly and robustly, without taking sides.

THE CLAIM OF "FAIRLY AND ROBUSTLY" IS UNPROVEN - THIS STATEMENT COUNTS AS THE PHSO'S OWN HEARSAY, NOT EVIDENCE; AND CANNOT BE PROVEN UNTIL THE PHSO IS ACCOUNTABLE.

THE PHSO DOES TAKE SIDES: JULIE MELLOR RESIGNED IN 2016 AFTER HER DEPUTY SIDED WITH A FORMER COLLEAGUE AT A NHS TRUST WHO HAD BEEN ACCUSED OF SEXUAL HARASSMENT

All complaints accepted for investigation are assigned to a named caseworker.

THIS STATEMENT IS SUCH A SLIGHT OF HAND THAT I AM ANGERED: ONLY THE FEW THOUSAND COMPLAINTS ACCEPTED FOR INVESTIGATION ARE ASSIGNED TO A NAMED CASEWORKER! THE OTHER 97% OF COMPLAINTS ARE HANDLED BY A DIFFERENT PERSON WITH PRACTICALLY EACH CORRESPONDENCE, AS I STATED IN THE ARTICLE

- Our decisions are final, but if a complainant thinks our decision is wrong, they can request a review. We will review a case if the complainant is able to show us that:
    - we made our decision based on inaccurate facts that could change our decision; or
    - they have new and relevant information that was not previously available and which might change our decision; or
    - we overlooked or misunderstood parts of the complaint or did not take account of relevant information, which could change our decision.

    SO HOW MANY TIMES HAS THE PHSO EVER AGREED WITH A REQUEST FOR REVIEW? I BET THE NUMBER IS CLOSE TO ZERO - I HAVE NEVER SEEN THE PHSO PROVIDE ANY DATA ON ITS RATE OF ADMISSION OF A REQUEST FOR REVIEW.

‘If the PHSO deigns to investigate at all, it refuses to investigate persons – only the organisations that have failed to satisfy complainants locally. In fact, the subjects of complaints are usually anonymized in reports. Consequently, the worst that the organisation can expect is a ruling that “mistakes were made,” for which it should apologise and perhaps compensate (to the inconsequential tune of a few thousand pounds), but no particular person is ever named as responsible.’

- Legislation prevents us from investigating individuals. However, where our investigation into what happened finds individual failure, referral is made to the relevant professional body.

THIS PROVES WHAT I WROTE IN MY ARTICLE: THE PHSO DOES NOT INVESTIGATE INDIVIDUALS - SO CANNOT HOLD INDIVIDUALS ACCOUNTABLE.

HOW MANY REFERRALS DOES THE PHSO MAKE "TO THE RELEVANT PROFESSIONAL BODY"? THE PHSO DOES NOT PROVIDE ANY DATA.

HOW DOES THE PHSO ENSURE THAT THE RELEVANT PROFESSIONAL BODY INVESTIGATE THE REFERRAL? IT DOES NOTHING BUT REFER.

IN THE SAM MORRISH CASE, ONLY ONE NURSE WAS EVER HELD ACCOUNTABLE AFTER A REFERRAL FROM THE PHSO - AFTER YEARS OF FRUSTRATING THE POOR PARENTS' COMPLAINTS.

JOURNALISTS AND POLICE HAVE PROVEN QUICKER AND MORE RELIABLE IN EXPOSING MEDICAL MALPRACTICE, BUT THEY ARE NOT FOCUSED ON IT; TO RELY ON THEM WOULD BE UNSYSTEMATIC. IN MANY CASES, NO HEALTH OR SOCIAL CARE AUTHORITY INVESTIGATES (OR REVERSES IT MISTAKEN RATING) UNTIL AFTER JOURNALISTIC EXPOSURE OR CRIMINAL INVESTIGATION.

- We use wide ranging powers to compel evidence from bodies and in 2016-17 used this to make over 1500 recommendations for things to be put right.

AND YET HEALTH AND SOCIAL CARE PERFORMANCE IS GETTING WORSE. 1,500 RECOMMENDATIONS IN 2016-17 COMPARES TO HUNDREDS OF THOUSANDS OF COMPLAINTS PER YEAR, WITHOUT IMPROVEMENT

- Where we uphold complaints the NHS must act on our recommendations, or can be required to account for why they will not to Parliament.

WHEN HAS THIS EVER HAPPENED?

• We regularly share findings from our casework to help Parliament scrutinise public service providers. We also share our findings more widely to help bring about improvements in public services and complaint handling.

THE PHSO LOVES THAT TERM "SCRUTINIZE"! "SHARING FINDINGS" IS NOT ACCOUNTABILITY

'For some reason, the Secretary of State and thence the PASC touted the system in 2014 for investigating airline accidents as their exemplar, but investigation is a purely reactive solution, and accidents are only one extreme form of failure, even if airline risks and health risks were analogous (they are not). In 2015, the PASC, in consultation with Hunt, recommended "a national independent patient safety investigation body," but specified the PHSO by another name.'

• The 2015 recommendation resulted in the creation of the Healthcare Safety Investigation Branch (HSIB), which came into operation in April 2017. It is a completely separate body to PHSO which conducts no blame investigations intended solely for systemic learning to improve patient safety. PHSO's role is to establish whether individual complainants have experienced un-remedied injustice.

I NEVER SAID HSIB WAS PART OF PHSO; HSIB IS A NO-BLAME INVESTIGATOR, SO IS USELESS FOR ACCOUNTABILITY.

AS I WROTE IN THE ARTICLE, I WANT A SINGLE ACTOR RESPONSIBLE FOR BOTH COMPLAINTS AND INVESTIGATIONS, AND IN WANT IT INSIDE THE DEPARTMENT OF HEALTH, SO THAT IT WOULD BE ACCOUNTABLE TO PARLIAMENT; QUANGOS ARE NOT ACCOUNTABLE TO PARLIAMENT.

Bruce Newsome: The key problem with the NHS. Not resources, not culture – but a lack of accountability

By Bruce Newsome

Bruce Newsome is Lecturer in International Relations at the University of California, Berkeley.

By international comparisons , British health and social care is inefficient and dissatisfactory: it is the most expensive health service in the world, but has more avoidable deaths, longer wait times, and unavailable services than almost all peers.

Bear in mind that twelve years have passed since around 1,200 avoidable deaths at Mid-Staffordshire Hospital, which were followed by multiple investigations and recommendations for change, and then more scandals.

Earlier this year, the long-standing Health Secretary admitted that parts of the NHS deliver “unacceptable ” care. Last week, we learnt that four out of ten care homes failed inspections during the first half of 2017 – a record rate. A separate freedom of information request revealed that violence and abuse against mental patients reached record levels in 2016. In the same week, Labour obtained evidence that English maternity wards closed temporarily 382 times in 2016 – another recent record. Naturally, by the end of the week, Jeremy Corbyn decided to refocus his criticisms of the Government on failures of health and social care.

While the Labour Party wants to blame austerity, the Conservative Government is in the habit of blaming culture, but nobody is discussing the overriding cause: accountability.

The false excuse of money

First, take the false excuse of money. The worst scandals occurred when the Labour government was throwing money at health and social services in the 2000s, which literally bankrolled the inefficiencies, internalisation, and self-righteousness that make fair analysis so unfashionable.

Since 2010, it has been easier to blame resources. For instance, the National Childbirth Trust recently reported that mothers in labour are being “treated like cattle” in NHS wards: half are reportedly left alone for hours without care or painkillers. The report’s authors – in consultation with the professional groups – chose to interpret the results as evidence for understaffing, when they could just as well be evidence for unprofessionalism.

Anybody using the NHS can see inefficiency: its posture is almost entirely reactive rather than preventative; the patient is forced into multiple appointments to meet staff who don’t work the same hours (unlike America, where departments are always open to patients with the time for an immediate referral); British staff waste time managing appointments in person (without the capacity for the patient directly to access their own doctors by telephone or internet), or interviewing patients to fill out forms that could have been filled out by the patients, or verbally describing risks that could have been read by the patients in their own time.

That’s before we consider the waiting times, which exacerbate costs, such that cancer patients are not treated immediately, or physiotherapy is not available soon enough after injury to prevent permanent damage. Bear in mind that these are all issues of supply or delivery, independent of increasing demand due to migration and unhealthier lifestyles.

Even emergency care shows avoidable inefficiencies. I’ll give personal observations: my local emergency room has three people on the reception desk, of which the first verbally interrogates, before referring the patient to the third person, who takes the same information for entry into a computer. The second person does nothing. The patient takes a seat, until a fourth person assesses the injury. None of these people actually treat the patient. The patient waits for hours – the Government’s target (since 2000) is less than four hours waiting for urgent care: the flow under my

observation was six persons in three hours: that's 30 minutes per patient, when no injury needed more than cleaning and dressing, and the staff outnumbered the patients. The general atmosphere is unhurried and uncaring – patients are treated as bothers, and ridiculed for their stupidity of injury.

The false excuse of culture

British public servants and politicians have fallen over each other in their eagerness to call for cultural change, without recommending the accountability that would drive cultural change.

In 2013, Julie Mellor, then the Parliamentary Health Service Ombudsman (PHSO), criticised the NHS for a "culture of defensiveness" and "a failure to listen to feedback" (together: a "toxic cocktail", in her words). Later that year, a clinical professor completed an inquiry into safety within the wider NHS, which recommended a legal duty for all healthcare workers to admit their mistakes, a "zero harm" culture, and "minimum staffing levels." In 2014, Jeremy Hunt promised an "open culture that learns from errors and corrects them", following the example of the airline industry. In 2015, Parliament's Public Administration Select Committee (PASC) " commend[ed] the Secretary of State's determination to tackle the culture of blame and defensiveness".

Ironically, criticising the "culture of blame" is a way of avoiding individual accountability. To blame "culture" is convenient for authorities that rationally want to avoid the blame. It's rational, but that doesn't make it right. It's also ineffective. Culture is an attribute of a group, so is no one person's fault.

Unaccountability

Focusing on culture change without accountability achieves nothing beyond a temporary change of awareness, until everybody re-acclimates to lack of accountability.

Unaccountable systems are riskier systems. Most practitioners are probably caring and ethical, but good intentions can be over-ridden by natural, everyday contradictions as simple as distraction. When practitioners are not held to account, they become less mindful and honest.

For instance, reconsider that report that four in ten care homes failed inspections so far this year. A newspaper calculated that rate, after the Care Quality Commission failed to report any rate by year: instead, it reported a rate of two in ten homes in the longer period since October 2014; moreover, it has successfully prosecuted only five care homes in two years.

Who is accountable for health and care failures? Parliament's Public Administration Select Committee (PASC) has reported that the authorities for investigating healthcare failures in Britain are too numerous and unaccountable. It counted more than 70 organizations involved in health complaints or investigations, of which "[n]o single person or organisation is responsible and accountable for the quality of clinical investigations or for ensuring that lessons learned drive improvement in safety across the NHS."

The ultimate authority for complaints against health and social care is the misleadingly titled Parliamentary & Health Service Ombudsman (PHSO), which is neither accountable to Parliament, nor responsible for any particular health or care service. No parliamentary committee or politician can overrule it. The PASC can only examine its reports.

As you would expect, the PHSO's unaccountability encourages the PHSO's irresponsibility. The PHSO usually refers complainants back to any of those 70-odd other organizations, until the complainants exhaust whatever complaints system exists at the organisational level – or (more commonly) the complainant gives up on a costly, confusing, and unrewarding system.

The PHSO traditionally has investigated only one per cent of complaints – as if 99 per cent of complainants had the time and motivation to complain unnecessarily. In 2013, Mellor suddenly promised a ten-fold rise in the number of PHSO investigations, but 10 per cent is as arbitrary as one per cent. The PHSO actually investigated less than eight per cent in the subsequent fiscal year, or merely 2,199 complaints; the NHS alone received 175,000 complaints that year. The PHSO's own surveys show that more than 50 per cent of Britons who consider complaining about the NHS do not bother, expecting no useful result, and that staff are reluctant to properly investigate complaints because they expect retaliation from their own hierarchy. The PHSO advises persistent complainants that their only recourse is a judicial review – a civil legal action beyond the resources of anybody but the fabulously rich.

The PHSO routinely fails to acknowledge complaints, claims that complaints are incomplete or improper, misaddresses responses, or reduces or reinterprets complaints. The complainant has no right of appeal against the PHSO. The PHSO dedicates no case officer to a complaint – thus, complainants are forced to deal with a different correspondent with almost every reply.

If the PHSO deigns to investigate at all, it refuses to investigate persons – only the organisations that have failed to satisfy complainants locally. In fact, the subjects of complaints are usually anonymized in reports. Consequently, the worst that the organisation can expect is a ruling that "mistakes were made," for which it should apologise and perhaps compensate (to the inconsequential tune of a few thousand pounds), but no particular person is ever named as responsible.

A Complaints and Accountability Office

Years have gone by since these flaws were publicized, without reform.

For some reason, the Secretary of State and thence the PASC touted the system in 2014 for investigating airline accidents as their exemplar, but investigation is a purely reactive solution, and accidents are only one extreme form of failure, even if airline risks and health risks were analogous (they are not). In 2015, the PASC, in consultation with Hunt, recommended "a national

independent patient safety investigation body," but specified the PHSO by another name.

Mellor herself resigned in July 2016 after admitting to mishandling correspondence about her deputy, who had resigned in April after evidence emerged of his cover-up of sexual harassment by a fellow executive at a NHS Foundation Trust. Her replacement is (unlike her) a career ombudsman, but his staff could be anybody – the public can demand no transparency about their qualifications or performance.

In 2016, the Government published a Bill to create a Public Service Ombudsman that would absorb the responsibilities of the PHSO. This would replace one quango with another. The authority that should be accountable for a public service should be the deliverer – in this case, the Department of Health, because government departments are accountable to Parliament and thence the electorate; quangos are not.

The department happily informs hundreds of complainants per month that it has no role in complaints. In reply to the PASC in 2015, the Secretary of State ruled out a complaints department on bogus logistical grounds. The department must establish its own Complaints and Accountability Office, which in turn must be accountable to the Secretary of State and thence to Parliament, for a more efficient and effective healthcare system for all Britons.

Maria Mansfeld
Head of External Communications
Parliamentary and Health Service Ombudsman
[redacted]
W: www.ombudsman.org.uk

From: Paul goodman [redacted]
Sent: 15 August 2017 13:42
To: Mansfeld Maria
Subject: Re: Blog by Bruce Newsome

Maria -

Let's proceed as discussed. Please send me a note.

Thanks,

From: Mansfeld Maria
Sent: 17 August 2017 10:31
To: [redacted]
Subject: RE: Blog by Bruce Newsome

Hi Paul

Many thanks for your time on the phone earlier this week.

As agreed, I've highlighted the inaccuracies in Bruce Newsome's blog on 13 August: 'The key problem with the NHS. Not resources, not culture – but a lack of accountability'. Please see below. This includes our response for background. Grateful if you could put this to Mr Newsome for his consideration.

I look forward to hearing from you in due course.

Kind regards
Maria

'The ultimate authority for complaints against health and social care is the misleadingly titled Parliamentary & Health Service Ombudsman (PHSO), which is neither accountable to Parliament, nor responsible for any particular health or care service. No parliamentary committee or politician can overrule it. The PASC can only examine its reports.'

- Contrary to the claim in the blog post, we *are* accountable to Parliament and our work is scrutinised by the Public Administration and Constitutional Affairs Committee.
- We were set up by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS in England and UK government departments. We are not part of government or the NHS in England. We are neither a regulator nor a consumer champion.

'As you would expect, the PHSO's unaccountability encourages the PHSO's irresponsibility. The PHSO usually refers complainants back to any of those 70-odd other organizations, until the complainants exhaust whatever complaints system exists at the organisational level – or (more commonly) the complainant gives up on a costly, confusing, and unrewarding system.'

- We are the last port of call for complaints that have not been resolved by the NHS in England and UK government departments. We investigate complaints fairly, robustly and without taking sides.
- The Health Service Commissioners Act sets outs the conditions under which we can accept complaints about the NHS. The law prevents us from conducting an investigation unless we are satisfied the NHS complaints process has been used and exhausted, or it was not reasonable to expect the complainant to have done so. It essential that NHS organisations have an had opportunity to resolve the issue locally before people bring a complaint to us.
- We publish detailed information on our website clearly explaining our role and how we work as well as investigation summaries which set out what our investigations have achieved.

'The PHSO traditionally has investigated only one per cent of complaints – as if 99 per cent of complainants had the time and motivation to complain unnecessarily. In 2013, Mellor

suddenly promised a ten-fold rise in the number of PHSO investigations, but 10 per cent is as arbitrary as one per cent. The PHSO actually investigated less than eight per cent in the subsequent fiscal year, or merely 2,199 complaints; the NHS alone received 175,000 complaints that year.'

- In 2016-17, we considered over 30,000 complaints and fully investigated more than 4,000 cases. Where we can, we will seek to resolve complaints and provide complainants with answers sooner, without the need for a full investigation.
- Of the 30,000 complaints we handled in 2016-17, three quarters weren't ready for us to look into. When people bring complaints that aren't ready for us, we give them advice on how best to progress their complaint.

'The PHSO routinely fails to acknowledge complaints, claims that complaints are incomplete or improper, misaddresses responses, or reduces or reinterprets complaints. The complainant has no right of appeal against the PHSO. The PHSO dedicates no case officer to a complaint – thus, complainants are forced to deal with a different correspondent with almost every reply'

- We handled over 120,000 enquiries in 2016-17, helping direct complainants to where their complaint could be most quickly resolved.
- We investigate unresolved complaints fairly and robustly, without taking sides. All complaints accepted for investigation are assigned to a named caseworker.
- Our decisions are final, but if a complainant thinks our decision is wrong, they can request a review. We will review a case if the complainant is able to show us that:
  - we made our decision based on inaccurate facts that could change our decision; or
  - they have new and relevant information that was not previously available and which might change our decision; or
  - we overlooked or misunderstood parts of the complaint or did not take account of relevant information, which could change our decision.

'If the PHSO deigns to investigate at all, it refuses to investigate persons – only the organisations that have failed to satisfy complainants locally. In fact, the subjects of complaints are usually anonymized in reports. Consequently, the worst that the organisation can expect is a ruling that "mistakes were made," for which it should apologise and perhaps compensate (to the inconsequential tune of a few thousand pounds), but no particular person is ever named as responsible.'

- Legislation prevents us from investigating individuals. However, where our investigation into what happened finds individual failure, referral is made to the relevant professional body.
- We use wide ranging powers to compel evidence from bodies and in 2016-17 used this to make over 1500 recommendations for things to be put right.
- Where we uphold complaints the NHS must act on our recommendations, or can be required to account for why they will not to Parliament.
- We regularly share findings from our casework to help Parliament scrutinise public service providers. We also share our findings more widely to help bring about improvements in public services and complaint handling.

'For some reason, the Secretary of State and thence the PASC touted the system in 2014 for investigating airline accidents as their exemplar, but investigation is a purely reactive solution, and accidents are only one extreme form of failure, even if airline risks and health risks were analogous (they are not). In 2015, the PASC, in consultation with Hunt, recommended "a national independent patient safety investigation body," but specified the PHSO by another name.'

- The 2015 recommendation resulted in the creation of the Healthcare Safety Investigation Branch (HSIB), which came into operation in April 2017. It is a completely separate body to PHSO which conducts no blame investigations intended solely for systemic learning to improve patient safety. PHSO's role is to establish whether individual complainants have experienced un-remedied injustice.

Bruce Newsome: The key problem with the NHS. Not resources, not culture – but a lack of accountability

By Bruce Newsome

Bruce Newsome is Lecturer in International Relations at the University of California, Berkeley.

By international comparisons , British health and social care is inefficient and dissatisfactory: it is the most expensive health service in the world, but has more avoidable deaths, longer wait times, and unavailable services than almost all peers.

Bear in mind that twelve years have passed since around 1,200 avoidable deaths at Mid-Staffordshire Hospital, which were followed by multiple investigations and recommendations for change, and then more scandals.

Earlier this year, the long-standing Health Secretary admitted that parts of the NHS deliver "unacceptable " care. Last week, we learnt that four out of ten care homes failed inspections during the first half of 2017 – a record rate. A separate freedom of information request revealed that violence and abuse against mental patients reached record levels in 2016. In the same week, Labour obtained evidence that English maternity wards closed temporarily 382 times in 2016 – another recent record. Naturally, by the end of the week, Jeremy Corbyn decided to refocus his criticisms of the Government on failures of health and social care.

While the Labour Party wants to blame austerity, the Conservative Government is in the habit of blaming culture, but nobody is discussing the overriding cause: accountability.

The false excuse of money

First, take the false excuse of money. The worst scandals occurred when the Labour government was throwing money at health and social services in the 2000s, which literally bankrolled the inefficiencies, internalisation, and self-righteousness that make fair analysis so unfashionable.

Since 2010, it has been easier to blame resources. For instance, the National Childbirth Trust recently reported that mothers in labour are being "treated like cattle" in NHS wards: half are reportedly left alone for hours without care or painkillers. The report's authors – in consultation with the professional groups – chose to interpret the results as evidence for understaffing, when they could just as well be evidence for unprofessionalism.

Anybody using the NHS can see inefficiency: its posture is almost entirely reactive rather than preventative; the patient is forced into multiple appointments to meet staff who don't work the same hours (unlike America, where departments are always open to patients with the time for an immediate referral); British staff waste time managing appointments in person (without the capacity for the patient directly to access their own doctors by telephone or internet), or interviewing patients to fill out forms that could have been filled out by the patients, or verbally describing risks that could have been read by the patients in their own time.

That's before we consider the waiting times, which exacerbate costs, such that cancer patients are not treated immediately, or physiotherapy is not available soon enough after injury to prevent permanent damage. Bear in mind that these are all issues of supply or delivery, independent of increasing demand due to migration and unhealthier lifestyles.

Even emergency care shows avoidable inefficiencies. I'll give personal observations: my local emergency room has three people on the reception desk, of which the first verbally interrogates, before referring the patient to the third person, who takes the same information for entry into a computer. The second person does nothing. The patient takes a seat, until a fourth person assesses the injury. None of these people actually treat the patient. The patient waits for hours – the Government's target (since 2000) is less than four hours waiting for urgent care: the flow under my observation was six persons in three hours: that's 30 minutes per patient, when no injury needed more than cleaning and dressing, and the staff outnumbered the patients. The general atmosphere is unhurried and uncaring – patients are treated as bothers, and ridiculed for their stupidity of injury.

The false excuse of culture

British public servants and politicians have fallen over each other in their eagerness to call for cultural change, without recommending the accountability that would drive cultural change.

In 2013, Julie Mellor, then the Parliamentary Health Service Ombudsman (PHSO), criticised the NHS for a "culture of defensiveness" and "a failure to listen to feedback" (together: a "toxic cocktail", in her words). Later that year, a clinical professor completed an inquiry into safety within the wider NHS, which recommended a legal duty for all healthcare workers to admit their mistakes, a "zero harm" culture, and "minimum staffing levels." In 2014, Jeremy Hunt promised an "open culture that learns from errors and corrects them", following the example of the airline industry. In 2015, Parliament's Public Administration Select Committee (PASC) " commend[ed] the Secretary of State's determination to tackle the culture of blame and defensiveness".

Ironically, criticising the "culture of blame" is a way of avoiding individual accountability. To blame "culture" is convenient for authorities that rationally want to avoid the blame. It's rational, but that doesn't make it right. It's also ineffective. Culture is an attribute of a group, so is no one person's fault.

Unaccountability

Focusing on culture change without accountability achieves nothing beyond a temporary change of awareness, until everybody re-acclimates to lack of accountability.

Unaccountable systems are riskier systems. Most practitioners are probably caring and ethical, but good intentions can be over-ridden by natural, everyday contradictions as simple as distraction. When practitioners are not held to account, they become less mindful and honest.

For instance, reconsider that report that four in ten care homes failed inspections so far this year. A newspaper calculated that rate, after the Care Quality Commission failed to report any rate by year: instead, it reported a rate of two in ten homes in the longer period since October 2014; moreover, it has successfully prosecuted only five care homes in two years.

Who is accountable for health and care failures? Parliament's Public Administration Select Committee (PASC) has reported that the authorities for investigating healthcare failures in Britain are too numerous and unaccountable. It counted more than 70 organizations involved in health complaints or investigations, of which "[n]o single person or organisation is responsible and accountable for the quality of clinical investigations or for ensuring that lessons learned drive improvement in safety across the NHS."

The ultimate authority for complaints against health and social care is the misleadingly titled Parliamentary & Health Service Ombudsman (PHSO), which is neither accountable to Parliament, nor responsible for any particular health or care service. No parliamentary committee or politician can overrule it. The PASC can only examine its reports.

As you would expect, the PHSO's unaccountability encourages the PHSO's irresponsibility. The PHSO usually refers complainants back to any of those 70-odd other organizations, until the complainants exhaust whatever complaints system exists at the organisational level – or (more commonly) the complainant gives up on a costly, confusing, and unrewarding system.

The PHSO traditionally has investigated only one per cent of complaints – as if 99 per cent of complainants had the time and motivation to complain unnecessarily. In 2013, Mellor suddenly promised

a ten-fold rise in the number of PHSO investigations, but 10 per cent is as arbitrary as one per cent. The PHSO actually investigated less than eight per cent in the subsequent fiscal year, or merely 2,199 complaints; the NHS alone received 175,000 complaints that year. The PHSO's own surveys show that more than 50 per cent of Britons who consider complaining about the NHS do not bother, expecting no useful result, and that staff are reluctant to properly investigate complaints because they expect retaliation from their own hierarchy. The PHSO advises persistent complainants that their only recourse is a judicial review – a civil legal action beyond the resources of anybody but the fabulously rich.

The PHSO routinely fails to acknowledge complaints, claims that complaints are incomplete or improper, misaddresses responses, or reduces or reinterprets complaints. The complainant has no right of appeal against the PHSO. The PHSO dedicates no case officer to a complaint – thus, complainants are forced to deal with a different correspondent with almost every reply.

If the PHSO deigns to investigate at all, it refuses to investigate persons – only the organisations that have failed to satisfy complainants locally. In fact, the subjects of complaints are usually anonymized in reports. Consequently, the worst that the organisation can expect is a ruling that "mistakes were made," for which it should apologise and perhaps compensate (to the inconsequential tune of a few thousand pounds), but no particular person is ever named as responsible.

A Complaints and Accountability Office

Years have gone by since these flaws were publicized, without reform.

For some reason, the Secretary of State and thence the PASC touted the system in 2014 for investigating airline accidents as their exemplar, but investigation is a purely reactive solution, and accidents are only one extreme form of failure, even if airline risks and health risks were analogous (they are not). In 2015, the PASC, in consultation with Hunt, recommended "a national independent patient safety investigation body," but specified the PHSO by another name.

Mellor herself resigned in July 2016 after admitting to mishandling correspondence about her deputy, who had resigned in April after evidence emerged of his cover-up of sexual harassment by a fellow executive at a NHS Foundation Trust. Her replacement is (unlike her) a career ombudsman, but his staff could be anybody – the public can demand no transparency about their qualifications or performance.

In 2016, the Government published a Bill to create a Public Service Ombudsman that would absorb the responsibilities of the PHSO. This would replace one quango with another. The authority that should be accountable for a public service should be the deliverer – in this case, the Department of Health, because government departments are accountable to Parliament and thence the electorate; quangos are not.

The department happily informs hundreds of complainants per month that it has no role in complaints. In reply to the PASC in 2015, the Secretary of State ruled out a complaints department on bogus logistical grounds. The department must establish its own Complaints and Accountability Office, which in turn must be accountable to the Secretary of State and thence to Parliament, for a more efficient and effective healthcare system for all Britons.

Maria Mansfeld
Head of External Communications
Parliamentary and Health Service Ombudsman
[redacted]
W: www.ombudsman.org.uk

Paul
----Original message----
From : [redacted]
Date : 15/08/2017 - 12:05 (BST)
To : [redacted]
Subject : Blog by Bruce Newsome

Hi Paul

I tried to call but couldn't get through to anyone.

I'm writing regarding Bruce Newsome's blog on 13 August: 'The key problem with the NHS. Not resources, not culture – but a lack of accountability'.

There were a few inaccuracies about us (PHSO) and how we operate in his post. Could I speak to someone about correcting those inaccuracies, please?

I look forward to hearing from you.

Kind regards,
Maria

Maria Mansfeld
Head of External Communications
Parliamentary and Health Service Ombudsman
[redacted]
W: www.ombudsman.org.uk

Our Service Charter explains how we work
Click here to find out more

Follow us on

_____
This email has been scanned by the Symantec Email Security.cloud service.
For more information please visit http://www.symanteccloud.com