From: [redacted]
Sent: 14 August 2017 19:03
To: Mansfeld Maria
Subject: FW: Conservative Home blog

Hi Maria,

I haven't had time to contact Conservative Home today and won't tomorrow. Can I leave this or could you pick it up?

Thanks,

[redacted]

From: [redacted]
Sent: 14 August 2017 13:15
To: Seddon Warren; [redacted]
Cc: Mansfeld Maria
Subject: RE: Conservative Home blog

Okay great, good to know. I'll give them a call and they may put me in touch with the author who I'll diplomatically ask to tweak some bits.

Maria –for info.

From: Seddon Warren
Sent: 14 August 2017 13:08
To: [redacted]
Subject: RE: Conservative Home blog

Have we managed to get ConHome to correct before? I thought they didn't usually do it (tho they will usually offer a blog offering a counter-view).

On the latter, I'm afraid that we don't have capacity this week to draft a response, but tbh I would leave this anyway (irritating as some of the inaccuracies are). It's a fairly random columnist as opposed to one of their heavier hitters and don't think it will get much traction.

W

From: [redacted]
Sent: 14 August 2017 12:36
To: [redacted]
Cc: Seddon Warren
Subject: RE: Conservative Home blog

Hi [redacted]

I've highlighted some additional inaccuracies om green below. I'd check with Warren on capacity for a response to the blog – [redacted] are on leave this week so might be a difficult to turn around in next few days if that is what you are after.

- 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 – This at best a mischaracterisation, we are legally required to ensure that a complaint has been through local complaints procedures before accepting it for investigation.
- In fact, the subjects of complaints are usually anonymized in reports. – We'd need to check this, I'm fairly sure we do not *fully* anonymise investigation reports we share with complainants, and the more important point is that our legislation sets restrictions on the publication of reports as a corollary to our wide ranging powers to compel evidence from bodies.
- In 2015, the PASC, in consultation with Hunt, recommended "a national independent patient safety investigation body," but specified the PHSO by another name. – This is a very misleading claim that should be also be picked up as it implies that HSIB is a complaint handling body. The 2 organisations have very distinct purposes, even if there are some areas of overlap. HSIB's investigations are intended solely for systemic learning, whereas our investigations are to establish whether individual complainants have experienced un-remedied injustice. During the course

Thanks

[redacted]

From: [redacted]
Sent: 14 August 2017 10:55
To: [redacted]
Subject: Conservative Home blog

Hi [redacted]

See the blog below about us which appeared on Conservative Home yesterday. It's very critical of us. I'm going to speak to them and correct any inaccuracies – highlighted in yellow. Could you review and let me know if there are any others I should raise?

In addition, we'd like to propose a response blog by us to Conservative Home outlining our independence and impartiality. Unfortunately Maria and myself are incredibly busy with [redacted] among other things so do not have capacity to do this. Is this something that someone in your team would be able to do? Obviously we won't propose it if we don't have capacity.

It'd be good to hear your thoughts.

Thanks,

[redacted]
Senior Communications Officer
Parliamentary and Health Service Ombudsman
[redacted]
W: www.ombudsman.org.uk

Follow us on

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.

From: Mansfeld Maria
Sent: 15 August 2017 18:47
To: Merzi Shareena
Subject: Re: Lines for clearance: Conservative Home - rebuttal

Thanks Shareena. I'll tweak the bit about the number of investigations as you suggest.
I Have checked it with policy but need to run a final version past ops tomorrow.

M

Sent from my iPhone

On 15 Aug 2017, at 17:45, Merzi Shareena [redacted] wrote:

> Well done Maria. Assume it's all been checked with policy and ops for factual accuracy?
>
> My only feedback is on the numbers. It's not that impressive quoting we investigate 4,000 of 100,000 enquiries (which is a bit of a misleading figure anyway). Could we say of the xx complaints we take a closer look at (assessment) we investigate xx or should we say something about increasing no of investigations we do. Anyway don't have access to annual report but point being we go for more impressive figures.
> Hope that makes sense but happy to talk through.
>
> Sent from my iPhone
>
> On 15 Aug 2017, at 16:56, Mansfeld Maria [redacted] wrote:
>
> > This message has been classified as **Sensitive.**
> > Hi Shareena
> > I've spoken to the Editor of Conservative Home. He has asked us to put in writing the factual inaccuracies and our response so that he can put it to the author for consideration. He was open to amending the post or allowing a response.
> > See suggestions below – I've kept it purposely short and to the point to increase the chances of them accepting our corrections/comments.
> > Let me know your thoughts.
> > Thanks
> > 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. The law prevents us from conducting an investigation unless we are satisfied the complaints process has been used and exhausted, or it was not reasonable to expect the complainant to have done so. It essential that bodies 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.

- We are legally required to make sure that a complaint has been through local complaints procedures before accepting it for investigation. We receive more than 100,000 enquiries and investigate 4,000 unresolved complaints a year. Where we uphold complaints the NHS must put things right. See our latest annual report here for further information and our latest figures [insert link].
- Complaints are best resolved at the local level. When complaints are not resolved locally, people wait too long for answers and improvements are delayed unnecessarily.

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 investigate unresolved complaints fairly and robustly, without taking sides. Our decisions are final, but if a complainant thinks our decision is wrong, they can request a review. We will take a further look and conduct a review of the 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.
- All complaints accepted for investigation are assigned to a named caseworker.

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.

- We don't 'refuse' to investigate individuals. Our legislation prevents us from doing so. Equally our legislation sets restrictions on the publication of our reports as a corollary to our wide ranging powers to compel evidence from bodies.
- Where we uphold complaints the NHS must put things right.
- We regularly share findings from our casework to help Parliament scrutinise public service providers. We also share our findings more widely to help drive 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.

- This is a misleading claim as it implies that HSIB is a complaint handling body that conducts investigations in to individual cases. The two organisations have very distinct purposes. HSIB's conducts no blame investigations intended solely for systemic learning to improve patient safety, whereas our investigations are to establish whether individual complainants have experienced un-remedied injustice.
- We regularly share our casework to highlight systemic problems but the primary purpose of our investigations is establish if someone has suffered injustice due to service failure and to propose appropriate individual remedies.

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.

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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.

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2000s, which literally bankrolled the inefficiencies, internalisation, and self-righteousness that make fair analysis so unfashionable.

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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

From: Mansfeld Maria
Sent: 16 August 2017 18:27
To: Campbell Amanda
Cc: Merzi Shareena; Robertson Alex; Marsh Rebecca; [redacted]
Subject: RE: Conservative Home

Hi Amanda

Thanks for your feedback. I was repeating myself in places in an attempt to be very clear, but I will incorporate your changes as you suggest.

Many thanks
Maria

From: Campbell Amanda
Sent: 16 August 2017 14:24
To: Mansfeld Maria
Cc: Merzi Shareena; Robertson Alex; Marsh Rebecca; [redacted]
Subject: RE: Conservative Home

This message has been classified as **Sensitive.**

Many thanks Maria

I think this looks largely great. There are a few areas where I suggest some change – see below.

Happy to discuss.

Regards

Amanda

From: Mansfeld Maria
Sent: 16 August 2017 13:15
To: Campbell Amanda
Cc: Merzi Shareena; Robertson Alex; Marsh Rebecca; [redacted]
Subject: Conservative Home

This message has been classified as **Sensitive.**

Hi Amanda,

I have spoken to the editor of Conservative Home about the inaccuracies in the blog. He has asked us to put in writing the factual inaccuracies and our response so that he can put it to the author for his consideration. He was open to amending the post or allowing a response.

I've highlighted the inaccuracies/misleading statements and our proposed response below. I will send these to the Editor for background to start the conversation, not as formal spokesperson lines to be quoted in the piece.

Please let me know if you have any comments or anything to add.

Thanks
Maria

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- ~~We are legally required to make sure that complaints about the NHS have been through local complaints procedures before accepting them for investigation.~~ [DN: already said in previous answer]
- In 2016-17, we ~~handled~~ 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 ~~can~~ 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 ~~take a further look and conduct a~~ review ~~of the~~ 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.

- ~~We don't 'refuse' to investigate individuals. Our~~ Legislation prevents us from investigating individuals. However, where our investigation into what happened finds individual failure, referral is made to the relevant professional body. ~~doing so. Equally our legislation sets restrictions on the publication of our reports as a corollary to our~~
- 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 ~~put things~~ ~~right~~ 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 ~~This is a misleading claim as it implies that HSIB is a complaint handling body that conducts investigations in to individual cases. The two organisations have very distinct purposes. HSIB's~~ conducts no blame investigations intended solely for systemic learning to improve patient safety. PHSO's role is ~~,~~ ~~whereas our investigations are~~ to establish whether individual complainants have experienced un-remedied injustice.

- ~~We regularly share our casework to highlight systemic problems but the primary purpose of our investigations is establish if someone has suffered injustice due to service failure and to propose appropriate individual remedies.~~

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.

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A Complaints and Accountability Office

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

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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.

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