From the Ombudsman Robert Behrens CBE

Parliamentary and Health Service Ombudsman

Mr William Wragg MP
Chair, Public Administration and Constitutional Affairs Committee

By Email only

5 June 2020

Dear Mr Wragg,

Thank you for your letter of 18 May 2020, setting out PACAC's requests for additional information to support its scrutiny of PHSO. I have set out responses to each of these queries below.

2018-19 annual report and written evidence

1. Page 34 of your annual report described the number of days it has taken to close cases. Are these calendar days or working days? And could this be clarified in subsequent publications?

The number of days taken to close cases are measured in calendar days. This is the measure we use for the majority of our KPIs as it is easily understood by members of the public and better reflects the actual experience of our complainants. (The exception being our KPI to complete 90% of case reviews within 40 working days).

We will specify in our 2019-20 annual report that we are referring to calendar days. We plan to consider the feasibility of measuring durations in working days as part of an internal review of our KPIs later in the year.

2. **As explained on p.44, you "invest**ed £353,000 in new ICT capabilities and **technical infrastructure". Were there any teething issues with this new ICT** provision? And were there any write-offs under this investment?

Delivering the replacement of our ICT infrastructure and the first phase of replacing our Case Management System during 2019 were major undertakings. Both projects were delivered on time and within budget, and in the context of continuous consultation with case handlers. As with any project of this nature, the ICT team and a team of change champions were on hand to provide support to staff following implementation to work through any post go-live issues. These were addressed quickly and effectively.

3. Page 64 of your annual report noted that the Board commissioned an external independent review. What were the main learning points from this review?

In line with standard good practice, the 2018-19 external (i.e. independent) Board effectiveness review consisted of in-depth individual interviews with each of the board members – the Ombudsman, Executive Directors and Non-Executive Directors - using a semi-structured questionnaire.

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It focussed on the following four review objectives:

- assessing the Board's effectiveness in relation to developing and scrutinising PHSO's recent strategy, including the scale of its ambition and deliverability of the three core objectives;
- the most critical challenges facing the organisation and their governance implications;
- the current governance framework, especially how best to deploy the expertise of Board members; and
- existing governance practices and behaviours and how these might be improved.

The review found that the Board now operates with good and effective governance. Board members have shifted since 2017 from a forensic focus on operational concerns to more appropriate strategic and scrutiny behaviours. At the same time there was a recognition that there remained room to improve as well as a clear collective desire to do so.

Board processes and behaviours demonstrated trust and goodwill between the Ombudsman, Executive and Non-Executive directors.

Although the Board is non-statutory, and therefore technically only advisory to the Ombudsman, it is run in line with good practices in governance from across the public sector.

Areas for improvement raised during the review focused on improving the Board's ability to challenge constructively at Board meetings, especially regarding cross-cutting issues that linked risks and operational performance. A few improvements were suggested and adopted, including demonstrating greater transparency and explaining the PHSO's public impact, to help regain public trust in the organisation.

Board members also urged early and careful planning for senior leadership turnover, considering this activity to be essential to organisational sustainability and stability.

Board committees were seen to be functioning well, fulfilling their remits and assurance functions. Chairmanship of the committees was complimented and highly commended. Evidence from recent meeting minutes showed how each committee is conducted with probity, constructive challenge and good governance behaviours.

4. **Page 21 of your annual report describes "maintaining dialogue with… the Public Administration and Constitutional Affairs Committee" about your funding** requirements. How do you propose to maintain such a dialogue to keep the Committee informed of your funding requirements? Is there anything of which you need to notify us?

We are awaiting information from HM Treasury about what process they will be running for the next Comprehensive Spending Review (CSR). Once HM Treasury has published their process and timescales, we will begin preparing a bid.

To inform the bid, we are currently in the process of preparing a new 3-year corporate strategy. We will be consulting on this externally in the near future, but following the

oral evidence we recently gave to the Committee, I attach a draft outline. This remains a work in progress, although as you will see we have currently included some key draft objectives that would require investment. This includes helping embed the new Complaint Standards Framework and working with a university partner to develop a set of professional qualifications for staff that could also then be adapted for public sector complaints handlers more widely.

As we set out to the Committee in the oral evidence session, consultation so far suggests we could have a real impact on the qualty of public sector complaint handling through this work, while also developing a framework that could be valuable for the ombudsman sector in general both nationally and internationally. Support in principle for our role in this area as part of the Committee's report on its scrutiny of our role could be valuable in our discussions with HM Treasury about the next CSR. We will discuss how this might be approached with the Committee Chair.

5. In your written evidence, you describe the establishment of a new Expert Advisory Panel, which brings support and challenge to improve the organisation. Could you please provide more information on:

    a. How the panel works in practice, and how the panel brings support and challenge to the PHSO;

    b. **How long panel members' tenure lasts; and**

    c. **Whether you have plans to change the panel's membership from time to** time, to ensure there is always fresh external challenge.

The Expert Advisory Panel provides a non-executive advisory function to the Ombudsman. Members are not PHSO employees and the Panel is not a decision-making forum. Members were selected on the basis of fair and open competition. The Panel is distinct from our Board and members offer challenge and support in general and in specific areas of PHSO's work where the Ombudsman would find that useful. This has included providing advice on casework-related matters and involvement in the development of the draft Complaint Standards Framework. Panel members are accountable directly to the Ombudsman and are called upon individually to work on projects and other activity as agreed by the Ombudsman. The Panel meets collectively from time-to-time.

Membership terms are limited to two years, with the option of annual extensions up to a total of five years. This will ensure the Panel's expertise is relevant to the changing priorities of the organisation and capable of being refreshed.

6. Why does the PHSO use KPMG as its internal auditors, rather than the Government Internal Audit Agency?

We are independent of Government and accountable directly to Parliament. We therefore ran a competitive procurement exercise to appoint internal auditors informed by the Government Internal Audit Agency's framework. Following this process, RSM replaced KPMG as our internal auditors.

Handling of Mr Nic Hart's complaint

7. One of the failures identified in the review concerned handovers between caseworkers. The review notes that guidance says that caseworkers must produce written handover noted before leaving the organisation. What are you doing to ensure that this is done? Also, is it best practice within the PHSO for caseworkers to introduce their successor to complainants to help build trust?

Managers now ensure that any staff member who is leaving PHSO produces handover notes about their cases and, where it is possible, will inform the complainant about who will be taking over responsibility for their case and when they will be in touch. All information, including a handover note, is available on our new Case Management System so that a caseworker picking up a case has access to all the relevant information relating to the case and the progress to-date.

8. Another failure that was highlighted was about communication with Mr Hart. The Committee often received submissions from the public concerned about the length of time for which they do not receive answers to their correspondence. Does the PHSO have target times to respond to correspondences, and if not, would you agree to include target times for correspondence in your KPIs, along with your Service Charter?

Caseworkers aim to respond to correspondence from complainants within ten working days, although there are no target times set out in our KPIs or Service Charter specifically in relation to this. We will include this as an internal service standard in our Service Model Policy and Guidance, which we will publish on our website.

9. Mr Hart described his distress at the misplacing or potential misuse of his personal information and private information about his daughter. Has a full assessment **been made of the risk to Mr Hart's personal data of the failure to follow the PHSO's data sec**urity procedures?

This situation pertains to the use of a personal mailbox by Dr Bill Kirkup when working as an external investigator on the case. As we explained in the review, Dr Kirkup took this approach, authorised by previous senior managers, following a breakdown of trust between Mr Hart and the organisation. Mr Hart was offered the opportunity to communicate with Dr Kirkup using his personal email and mobile telephone number and he agreed to do this. Dr Kirkup has provided a detailed account of this issue in his note at Appendix C.

The use of a personal email account for case information was logged as a data incident in 2016. We identified that data handling policies were not being followed as information exchanged with Dr Kirkup to his personal email was not always replicated in the Case Management System. We therefore asked Dr Kirkup to return copies of all outstanding emails and these were stored against the complaint on our Case Management System.

10. Mr Hart explained to us that the PHSO failed to assure him that evidence he **submitted was given the proper weight. How do the PHSO's caseworkers seek to** assure complainants that their evidence has been given proper weight? (For example, is all evidence the complainant submitted commented on, to actively demonstrate it has been considered?)

In decision letters and investigation reports, we set out the evidence we relied on when explaining the decision we have made. On 7 May this year, we published guidance for complainants explaining the approach we take when considering and assessing evidence. Further training for casework staff about how to effectively balance evidence and explain our decisions is also under development as part of our commitment to continuous improvement.

11. Please could you set out each failing found by the review, the actions proposed to be taken in response (including those that had already been implemented by the time the review was completed) and target dates for completing any actions still outstanding.

This is set out in Appendix A. We have also appended comments made by independent Expert Advisory Panel member James Titcombe on an early draft of the review of PHSO's handling of Mr Nic Hart's complaint (Appendix B).

Other matters

12. **The Committee has received representations critical of the PHSO's lack of accommodation of complainants' reasonable adjustments. What is the PHSO's** po**licy for complainants' reasonable adjustments? Does the PHSO require** complainants to justify their need for reasonable adjustments?

Our policy for considering reasonable adjustments is set out below. We do not require complainants to justify their need, although we will talk to a complainant to understand their needs and if appropriate make an alternative suggestion based on our knowledge of our process as to how we can best accommodate this. Where it is not reasonable for us to agree an adjustment, we will try and find an alternative solution that will work for the complainant.

Requests for reasonable adjustments under the Equality Act 2010

1.11 If we receive a request for a reasonable adjustment, at any stage of the casework process, then it must be fully considered under the Equality Act and its related Codes of Practice. (Legal requirement)

1.12 Any request for a reasonable adjustment should be added to the case. If we decide an adjustment is reasonable we should clearly record the individual's disability, what reasonable adjustments are requested and when we agreed, on the complainants Dynamics 365 record. Selecting their disability type form from the drop down menu and recording the adjustment requested in the accessibility

and reasonable adjustment section. Any questions about agreeing an adjustment should be escalated through line-management. (Policy requirements)

1.13 If we decide an adjustment is not reasonable then we should record what was requested, when it was requested and the reasons why we determined it was not reasonable, in the accessibility and reasonable adjustment section on complainant's Dynamics 365 record. We should also consider if there are other ways we can assist the complainant. The Legal Team must be informed if we decide an adjustment is not reasonable. (Policy requirements)

1.14 A letter should be sent to the complainant confirming the outcome of the reasonable adjustment request and a copy of the letter should be attached to the complainant's Dynamics 365 record.

1.15 Assistance can be provided to caseworkers in considering a request for a reasonable adjustment by emailing ++edicasework@ombudsman.org.uk.

1.16 All requests for additional accessibility outside of the Equality Act 2010 should be recorded in the accessibility section of the complainant's Dynamics 365 record.

1.17 If during our consideration of a case we are provided with information that suggests an adjustment to our service may be required, we should consider raising this with the complainant. (Policy requirement) For example, if a complainant's case refers to them being partially sighted, but they have not specified they want large font print, we may wish to ask if this is required.

13. In one piece of written evidence, it was suggested to the Committee that the PHSO is not well-equipped to deal with complaints about HS2 Ltd. It was put to us that investigations into HS2 require specialist knowledge and a body should be **established that can compel HS2 Ltd to "put things right" (rather than simply** providing recommendations). What is your response to that?

We do not agree that HS2 (or similar projects) should be taken out of the Ombudsman's remit. Taking functions away from PHSO confuses the redress landscape for service users and is in clear tension with the drive towards creating a single Public Service Ombudsman in England. We have established a high-risk case handling process to deal with issues arising from complex cases and can have a clear impact for the public when considering when things have gone wrong.

For example, in 2015 we laid a report before Parliament following an investigation we conducted that looked at HS2 Ltd's communication and engagement with a group of local residents. We found that overall HS2 Ltd's actions fell below the reasonable standards we would expect and constituted maladministration.

This prompted further scrutiny by Parliament into the concerns raised by the complainants that came to us. Your predecessor Committee followed up our investigation and found that, "PHSO's report exposed fundamental cultural problems with

the way that HS2 Ltd communicates with affected residents". PACAC also noted that "we welcome the improvements made by HS2 Ltd to its complaints handling process since the publication of the PHSO report".

As part of this follow-up inquiry HS2 confirmed to the Committee that these improvements had included instituting a 24 hour helpdesk for the public and mandatory training in complaints handling for all staff. The Government also highlighted to the Committee that in light of the report we had laid before Parliament it had "requested that HS2 Ltd present their plans to ministers to ensure that they are sufficiently robust to deal with the issues that the PHSO … report identif[ies]". This shows the clear impact that we can have in such cases.

We continue to receive complaints about HS2 and while we cannot comment on any current investigations, I can confirm to the Committee that we will highlight to it any significant issues that we identify and believe warrant further parliamentary scrutiny.

14. One member of the public, who though not a member of WASPI submitted a complaint to DWP following their advice, has expressed frustration at the ongoing delay in investigating these cases. I note your website states that you cannot provide ongoing commentary as you must investigate in private but are you able to provide any expected timeframe for the six sample complaints to be investigated?

Our investigation into these complaints was delayed by judicial proceedings which were intended to examine the same issues as we were to consider. Once we had examined the Court judgement, we took legal advice and found that delaying further to await the Court of Appeal outcome was not necessary, as we were considering different matters to those being considered by the Court. Our investigation therefore commenced on 18 March 2020.

We are not able to give a precise timeframe for the investigation of the six sample complaints as this will be determined by its complexity and the amount of evidence we receive. We aim to complete the investigation in a timely manner, whilst also ensuring that we thoroughly consider the issues set out in the six sample complaints.

Additional information relating to the Service Charter

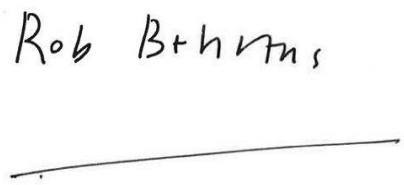
During the scrutiny hearing, the Committee also considered the Service Charter, which sets out feedback from complainants and organisations about their experience of PHSO's service. On the recommendation of your predecessor committee, we commissioned an independent research agency to look at how best we can seek feedback on whether complainants feel the service we provide is impartial. We will be publishing the findings of this research on our website shortly and it is appended to this letter.

Overall, the research concluded that PHSO should combine the feedback we already receive from complainants and organisations on a number of key Service Charter commitments that directly relate to fairness. This total score will give a well-rounded score on whether PHSO has demonstrated it has acted fairly. We will therefore take the average of the scores on Service Charter commitments 5, 8, 9 and 11 to provide an

overall score on whether our users feel we are making fair and impartial decisions. This will be included in our regular quarterly reporting on our Service Charter later in 2020.

I would be happy to discuss any of these issues in more detail. Please contact my Assistant Private Secretary, Faye Glover, faye.glover@ombudsman.org.uk should you wish to arrange a phone call or meeting.

Yours sincerely,



Rob Behrens CBE
Ombudsman and Chair
Parliamentary and Health Service Ombudsman

Appendices:

A. **Summary of failings identified in PHSO's handling of Mr Nic Hart's complaint,** and action taken in response
B. Comments made by independent Expert Advisory Panel member James **Titcombe on an early draft of the review of PHSO's handling of Mr Nic Hart's** complaint
C. **Dr Bill Kirkup's response to Mr Nic Hart's written evidence to PACAC's scrutiny** inquiry
D. Summ**ary of findings of independent research into measuring complainants' views on PHSO's impartiality**
E. First draft of 2021-24 PHSO Corporate Strategy

Appendix A: **Summary of failings in PHSO's handling of Mr Nic Hart's complaint and actions** taken in response

5th June 2020

The table below sets out the failings identified by the review of PHSO's handling of Mr Nic Hart's complaint. It also sets out how PHSO is responding or has responded to each failing, and when each action is planned to be complete. The page numbers in the table below refer to the report of the review, which was published on PHSO's website in January 2020.

	Failings	Actions taken in response	Planned completion date
p.8	1. Time taken to close the case It took much too long to complete PHSO's investigation into Mr Hart's complaint.	a. PHSO's procedures and working practices now focus on case progression, ensuring that undue time is not spent with inactivity on a case. Managers in PHSO's casework teams receive a daily update on the progress and age of every case to manage throughput and to identify cases that are not making appropriate progress. b. PHSO is resolving more complaints at an earlier stage through early dispute resolution and early consideration. We closed 1,200 cases last year without the need for a full assessment and completed 92% within 12 weeks. Our Early Dispute Resolution pilot, which started in August 2019, has had some positive outcomes in bringing complaints to a successful conclusion, and is now moving into an implementation phase.	a. Complete b. Ongoing

p.9	2. Assigning caseworkers Not enough resource was allocated to work on the case at the outset.	a. PHSO now considers the resource a complaint needs when it first arrives and again when caseworkers carry out their initial checks. This helps to make sure that each complaint is allocated to a caseworker with the appropriate skills and knowledge. Moreover, PHSO allocates additional resources to high risk cases when required. b. PHSO has developed a training and accreditation framework to ensure that caseworkers are equipped with the skills and knowledge to deliver an effective service. 66% of eligible staff have received accreditation. A further 12% are awaiting approval by the Board and a further 10% have been given an extension due to Covid-19. We expect by August 2020 that 88% of eligible staff will have been accredited. The remaining 12% started their accreditation last month and are due to complete this in April 2021.	a. Complete b. All eligible senior caseworkers to complete accreditation process by April 2021.
p.10	3. Handovers between caseworkers Personnel changes meant that Mr Hart had to build a relationship from scratch with each new caseworker and repeat his story multiple times. This made it harder for Mr Hart to build and maintain trust in PHSO and with the staff working on his complaint.	a. PHSO has introduced new ways of handling complaints since the conclusion of Mr Hart's case. Once a complaint is allocated to a caseworker, it is normally overseen by that same caseworker throughout the process until the case is closed. The exception being where the case is escalated to a more senior caseworker following a risk assessment. b. PHSO's guidance now sets out a specific process for managing handovers between caseworkers. This guidance says that caseworkers and their managers must do everything they can to reduce the need for handovers and to produce written handover instructions on all the cases they are handling before they leave PHSO.	a. Complete b. Complete

		c. PHSO has recently introduced a new Casework Management System using MS Dynamics 365 to replace an outdated system. Caseworkers are using a newly created handover section on the CMS where they can add their handover information.	c. Complete
p.11	4. Appointing an external investigator The role and responsibilities of the external investigator were not communicated effectively to Mr Hart or to the caseworkers who were already working on the case. This led to a degree of confusion as well as difficulties in building trust between those involved in investigating the complaint.	a. PHSO now sets out in writing clear expectations when bringing in external expertise to support its work. For example, when Expert Advisory Panel members are commissioned to carry out a piece of work, a consistent written process is used to define and communicate the nature of this work and what their role will be. This is shared with all relevant staff.	a. Complete
p.12	5. Communication with Mr Hart i. In November 2014, Mr Hart asked his caseworker for weekly updates on the progress of his case. The first caseworker provided regular updates in line with this request, but when other caseworkers started working on the complaint, communication with Mr Hart became less frequent and consistent. ii. Several meetings were arranged for Mr Hart to meet senior managers to discuss the case during 2016 and 2017. This led to a lack of clarity about whether caseworkers or senior managers were responsible for	a. Since Mr Hart's complaint was concluded, PHSO has changed its policies and guidance for caseworkers about how to communicate with complainants. Caseworkers now discuss with complainants their preferred frequency and method of communication and update them at specific milestones during the case. b. Once a complaint is allocated to a caseworker, this caseworker remains the single point of contact for the complainant throughout the lifetime of the case. This remains the case even in situations where the Ombudsman or his deputy become involved in decision-making.	a. Complete b. Complete

	communicating with Mr Hart. It also meant that Mr Hart was sometimes told different things by different people, making it hard for him to trust in the quality and consistency of PHSO's investigation.	c. As part of PHSO's professional skills training for caseworkers, all caseworkers are now trained to communicate effectively with complainants. This area of complaint handling is measured so caseworkers and managers can understand how well they are communicating with complainants and whether any improvement is required.	c. Complete
		d. PHSO has taken steps to support and challenge all staff members to achieve the right balance between being empathic and acting impartially during the complaint handling process. Caseworkers are trained in how to step back from a case and look at it impartially. All staff receive continuous feedback as part of their performance management on how they are demonstrating PHSO values and behaviours including impartiality.	d. Ongoing
		e. Later this year, PHSO will begin using a number of Service Charter feedback scores to understand how far complainants and the organisations investigated feel PHSO is impartial.	e. To be completed in late 2020
p.14	6. Recommendations for financial remedy In February 2016, during a meeting with former senior managers, Mr Hart was told that PHSO's investigation report would include an additional recommendation for financial remedy to be made by the organisations named in the complaint to reimburse Mr Hart for the costs incurred by his team.	a. Because of the commitment made and not followed through to ask the organisations to meet costs, PHSO has since offered to make a significant exceptional payment to Mr Hart. This payment is not intended to reflect actual costs. At the time of writing, Mr Hart has not accepted this payment.	a. This offer was made in Nov 2017 and again in Dec 2017, Jan 2020 and May 2020.

	This conversation was never followed up with any discussion about how such costs would be determined, nor was this understanding ever discussed with the organisations concerned. Former senior managers should not have approached the question of financial remedy in this way.	b. PHSO has strengthened the way decisions are made about the level of financial remedy to recommend in each case. Caseworkers check what has been recommended previously in similar cases and the Severity of Injustice Scale, introduced in June 2018 helps them make decisions about financial remedy. Caseworkers are also expected to consider any money that has already been recommended or paid out by other organisations, awarded by courts, or paid following mediation before legal action.	b. Complete
p.15	7. Information security The external investigator appointed by PHSO gave their personal contact details to Mr Hart to offer a more personal and responsive service without having to go via PHSO. This approach had been discussed and agreed with a former senior manager at PHSO. Mr Hart made use of the external investigator's offer, contacting them using their personal email address and telephone number. The external investigator tried to ensure that all information related to the investigation was copied to and stored securely on PHSO's central case file. However, a small number of emails were not passed on until a later date. This meant that PHSO could not guarantee that information was saved correctly or shared securely.	a. PHSO now has much stricter procedures and policies in place to make sure that information is stored securely and shared safely. During the last year, PHSO has updated its policies to provide clearer guidelines to staff on how to record and store information. These policies have also been updated to make sure they comply with the General Data Protection Regulation (GDPR). PHSO's updated policies are accessible to all staff via the intranet and quality assured by an internal team. As part of their induction, all staff complete a GDPR e-learning course and receive training on how to handle information securely. Should any data breach occur, we will immediately follow our duty to self-report this to the Information Commissioner's Office, as we recently described in evidence to the Committee. b. In situations where PHSO has asked an external person to work with the organisation, they are asked to complete a questionnaire on information security and data protection that makes sure they are working in line with internal ICT, security and information governance polices.	a. Complete b. Complete

p.15-16	8. Involvement of senior managers Several former senior managers were directly involved in making decisions about how to handle Mr Hart's complaint. As a result, PHSO's approach changed several times during the course of the investigation. This meant that Mr Hart received mixed and sometimes contradictory messages about what PHSO was doing and why. While there may occasionally be legitimate reasons to change the way an investigation is carried out, any changes should be made impartially and based on evidence. In Mr Hart's case, the changes in PHSO's approach not only contributed to the length of time it took to complete the investigation, but also made it hard for Mr Hart to have faith in the quality and consistency of PHSO's investigation.	a. PHSO now communicates with complainants so it is clear from the outset how the caseworker will approach an investigation. Before starting an investigation, a caseworker must set out in writing what they will and will not look at during the investigation as well as how they plan to do this. b. In high risk or complex cases, the investigation plan is agreed at the outset by a senior manager, which can be the Ombudsman or one of his deputies, who will then have regular oversight of the investigation. The caseworker coordinates all work and remains the single point of contact for the complainant. c. The culture at PHSO has also changed significantly since Mr Hart's case was investigated. This means that when senior managers or the Ombudsman and his deputies are involved in an individual case, there are regular discussions with the caseworker to agree a way forward. This helps to make sure that all decisions about individual cases are informed by caseworkers' detailed knowledge of the case.	a. Complete b. Complete c. Complete
p.16	9. Explaining how PHSO uses evidence and makes judgements The evidence provided by both Mr Hart and the organisations was given equal consideration and draft reports were written drawing on comments from all parties. However, PHSO failed to	a. PHSO has changed the way it involves complainants in the later stages of an investigation by replacing draft reports with provisional views. This gives all parties an equal and contemporaneous opportunity to comment and provide any additional evidence to the caseworker before they make their final judgements and conclude their investigation report.	a. Complete

	communicate effectively to Mr Hart how it had used his evidence, or to assure him that it had been given equal weight. This undermined Mr Hart's faith in the impartiality and robustness of PHSO's investigation.	b. PHSO has updated its policies and guidance to be more explicit that evidence should be considered equally, whether it is provided by complainants or by organisations complained about. PHSO has recently published guidance for caseworkers on assessing the balance of evidence.	b. Complete
p.17	10. Clinical advice i. There were inconsistencies in the way that clinical advice was requested by different caseworkers and the way it was provided. Sometimes different clinical advisers provided contradictory advice. PHSO lacked clear processes about how to deal with contradictory views in an effective and timely manner. ii. The long time it took for PHSO to obtain comprehensive and robust clinical advice also contributed to the length of time it took to conclude the investigation.	a. PHSO commissioned an independent Clinical Advice Review, chaired by Sir Alex Allan, a non-executive member of PHSO's board. Sir Liam Donaldson, the former Chief Medical Officer for England, was appointed as an Independent Adviser. The review reported and published its findings in March 2019. b. PHSO published a new version of the Ombudsman's Clinical Standard in August 2018. This places a greater focus on understanding whether the clinical care complained about was based on existing clinical guidance or good practice. c. PHSO now has a clear process for what to do when it receives contradictory clinical advice. If this happens, PHSO's lead clinician will help the caseworker to decide on the appropriate steps to take. This could involve, for example, giving clinical advisers sight of each other's advice or asking clinical advisers to review the evidence they based their advice on. d. Peer review of clinical advice obtained is now in place for all of the more complex cases and, in exceptional circumstances, PHSO will seek evidence from an additional clinical adviser who can offer a fresh perspective.	a. Complete b. Complete c. Complete d. Complete

		e. Lead clinicians also review all written advice provided by external clinical advisers to assure its quality and consistency.	e. Complete
		f. PHSO plans to share clinical advice with complainants prior to drafting the Provisional Views on the case. We are currently reviewing feedback from the pilot and will be making modifications to the process before rolling this out. This will be supported by guidance for complainants setting out how clinical advice and evidence will be used and how they and the organisations complained about can be involved with this process.	f. To be rolled out from 1 August subject to re-opening health casework.
		g. Caseworkers and clinical staff now have the opportunity to comment on each other's work. For example, clinical advisers can now feed back on the quality of requests for advice from caseworkers on a case and caseworkers can now feed back on the quality of the clinical advice they receive. This survey data will be analysed and inform training, advice, guidance and process changes.	g. Complete

Appendix B

Report of a review into the Parliamentary and Health Service Ombudsman's handling of Mr Nic Hart's complaint from August 2014 to December 2017

Review by James Titcombe, member of PHSO's independent Expert Advisory Panel – 4th of December 2019

Background

I have been asked to review the above report relating to the PHSO's handling of a complaint by Mr Nic Hart relating to the tragic loss of Mr Hart's daughter Averil, following serious failure in her care across a number of organisations. Specifically, I have been asked to address the following points:

- Consider if there was more that PHSO could have done to identify and explain the failings.
- Consider if PHSO's response to the failings identified was appropriate.

In carrying out this review I have read the above report as well as the following documents:

- Ignoring the alarms: How NHS eating disorder services are failing patients - PHSO (2017)
- Ignoring the Alarms follow-up: Too many avoidable deaths from eating disorders – PACAC (2019)

Over the last few years I have met Mr Hart on a few occasions, and I have also exchanged emails and messages with Mr Hart via social media. In 2017, Mr Hart gave a powerful and moving presentation to myself and others at Imperial College, London as part a post graduate programme of study in patient safety.

Comments/Observations

I must begin by expressing my deepest condolences to Mr Hart and his family for the tragic loss of Averil. From my reading of the documents as well as my personal contact with Mr Hart over the years, I can only begin to understand the depth of Mr Hart's loss and the extraordinary efforts he has undertaken to in order to try and gain an acknowledgement of the failures in Averil's care and ensure there is system wide learning from what happened.

Reading the 2017 PHSO report, I note that the way in which several organisations responded to complaints by Mr Hart about Averil's care was so poor that it was found to have amounted to maladministration. As Mr Hart was experiencing these responses the additional distress, hurt and frustration he experienced must have been immense.

I note that Mr Hart made a complaint to PHSO in August 2014, almost 2 years after Averil's tragic death in December 2012 and that the complaint resulted in the publication of a report by PHSO in December 2017 more than 3 years after the initial complaint was made.

I understand that in July 2019, a meeting took place whereby PHSO set out its intention to conduct a review into the handling of Mr Hart's complaint. This review was due to be published in August, however the publication date has been delayed until after the election on 12th December.

Having read a draft version of this report (dated December 2019), it is clear that this review has identified a number of serious failures relating to how the PHSO handled Mr Hart's complaint.

The failures identified include:

Time taken to close the case

The review is clear that the time it took to complete the case (3 years and 4 months) was unacceptable.

Resourcing of the case

The review found that there was no clear and consistent plan in place to resource the investigation.

Communication with the complainant

The review highlights that five caseworkers worked on the case at different times and acknowledges that these personnel changes meant that Mr Hart had to frequently build new relationships and re-tell his story. Confusion also developed as to who was Mr Hart's main point of contact and PHSO staff made commitments that were not kept.

Appointment of an external investigator

The report states that when an external investigator was appointed to work on Mr Hart's complaint in April 2016, the role and responsibilities were not clearly communicated, and this led to confusion for all those involved.

Decision-making

The report states that several different former senior managers directed caseworkers to change their approach in how they carried out the investigation into Mr Hart's complaint and that this resulted in Mr Hart receiving mixed and sometimes contradictory messages about what PHSO was doing and why.

Use of evidence

The review states that PHSO failed to clearly explain to Mr Hart how his evidence had been used or to assure him that it had been given equal weighting in the investigation. A large amount of clinical advice was sought, but there were inconsistencies in the way this was requested and provided, and there was not a robust process in place when different clinical advisers provided contradictory advice.

As I read the review, I couldn't help but reflect on how this process must have felt to Mr Hart, who at the time of referring his complaint to PHSO, had already been through more than 2 years of inadequate responses from many of the organisations involved in Averil's care.

I note that the review states that trust between Mr Hart and PHSO become completely broken. In my opinion this breakdown of trust is an inevitable outcome of the many serious failures in PHSO's handling of the case as detailed in the review.

Could PHSO have done more to identify and explain the failings?

In order to give a fully informed opinion on this point, I feel that it would be important to have a discussion with Mr Hart to ensure that I was fully aware of his experience and perspective. However, based on the information provided I make the following observations and comments.

Firstly, in my opinion it is clear that when Mr Hart made his initial complaint to PHSO in 2014, the organisation was not fully fit for purpose in terms of the systems, processes and resources needed to effectively investigate the concerns Mr Hart raised involving multiple organisations involved with Averil's care.

It seems apparent that as time went on the gap between what Mr Hart was rightly expecting of PHSO's approach to investigating his complaint and the reality of his experience grew ever greater.

The review suggests that in several instances PHSO staff tried to put in place additional measures they hoped would help. However, whilst these actions will no doubt have been motivated by good intentions, a lack of structure and proper systems and oversight sometimes meant that these actions led to increased confusion and a further breakdown of trust and confidence. In addition, some of the actions resulted in agreements being made that were outside normal PHSO policy.

The review that has been carried out identifies significant failures in PHSO's handling of the case and details a number of substantial changes that have been made since 2017. I also note that PHSO have previously acknowledged that lessons needed to be learned from how the case was handled and have previously issued an apology to Mr Hart for this.

It is not possible for me to know whether or not this review addresses all of Mr Hart's concerns relating to the PHSO's handling of the case, but from the information I have read, it does seem to me that the review is detailed and has identified a number of very serious failures in a frank, open and honest way.

The extent and seriousness of these failures will make uncomfortable reading for everyone involved, but I believe that such a frank acknowledgment of the issues as well as a clear understanding of the impact on Mr Hart is an indication of a positive learning culture.

I note that the final report relating to Mr Hart's complaint was published in December 2017 and the decision to carry out a review of the handling of the case was made in July 2019, more than 18 months later. This suggests that there may have been an opportunity to initiate a review process to learn lessons from the handling of the case earlier.

PHSO might consider whether a more routine process to establish learning opportunities following the closure of complex casework could be introduced, where any significant concerns raised automatically trigger a more in-depth internal review process earlier on.

Is PHSO's response to the failings identified appropriate?

The review details a number of significant areas of change within PHSO since the time Mr Hart's complaint was closed. These measures include processes designed to ensure consistent allocation of caseworkers, a new casework management system, a training and accreditation framework for caseworkers, improvements in data governance arrangements, training for staff on communication and updated policies and guidance on how evidence from organisations and complainants should be equaly considered.

A significant issue highlighted by the review relates to the way expert clinical advice was requested, how it was presented and how contradictory views obtained by external advisers was dealt with. The review highlights a number of changes that have been made in this area, including the introduction of clear processes for resolving contradictory clinical advice and a process of peer review.

The review also highlights the current pilot underway whereby complainants are given an opportunity to see clinical advice and to have a meaningful discussion about its significance with their caseworker. This feels like an important initiative that could have reduced some of the difficulties experienced in this case.

The significant changes detailed in the review demonstrate that PHSO as an organisation are not standing still and in my view, the number of changes already made show a determination at all levels of the organisation to significantly improve the way in which complex cases like this are handled in the future. However, I believe it is also fair to point out that it is still early days and that some important initiatives relevant to this case are still in pilot phase. The seriousness and extent of the failures identified by this report must result in a sustained commitment to embed and build upon the changes already made.

Whilst the review details several very positive changes and actions in progress, it doesn't provide details of how actual improvement in the handling of complex casework against the issues identified in this report will be monitored and measured.

PHSO might wish to consider if some indicators could be used/developed, incorporating feedback from complainants involved in complex investigations, to monitor and measure progress against the issues this report has identified.

Conclusions

Reading this review has made me reflect on the experience of Mr Hart in the years since Averil died. To have experienced the responses he did when raising complaints with the organisations responsible for Averil's care must have been unbearably hard. To have then turned to PHSO, only to face a hugely protracted and difficult process whereby so many failures in the handling the case took place must have been a dreadful experience.

From the information I have read, I do believe PHSO's review of the handling of the case has been frank and honest about the seriousness and extent of the failures that occurred. I also believe that the actions that have been taken by PHSO since demonstrate a commitment to making changes towards ensuring other complainants in the future do not experience the

same issues Mr Hart faced. However, I believe that PHSO should give some consideration to how it might monitor and measure actual progress against the issues identified incorporating feedback from complainants involved in future complex cases.

In finishing, I would like to again offer my condolences to Mr Hart for the tragic and avoidable loss of his daughter Averil and I would like to pay tribute to Mr Hart for the incredible efforts he has gone to in order to push for truth and learning from what happened.

Appendix C

To: Rob Behrens, Parliamentary and Health Services Ombudsman

From: Dr Bill Kirkup Date: 14 May 2020

MR HART'S EVIDENCE TO PACAC

You asked me to comment on this submission. I was disappointed by its nature and tone, although I do understand that it originates from the pain of the original events, as well as a lack of acceptance of both the PHSO reports and the subsequent review.

It seems to me that the fundamental reason is his disagreement with the findings on supervision and the care coordinator role. We reviewed these points many times, both internally and in discussion with NH, but the PHSO decision was based on the evidence available and on the expert opinion. It is a pity that although probably 95% of the findings in the report coincided with his view, all of the subsequent response has been based on the other 5%, particularly supervision and care coordination.

The lack of acceptance may be understandable, but it does not make the report itself of 'poor quality' or imply 'gross errors': these are differences of opinion not matters of fact, and in the end the judgement properly rests with PHSO as an independent adjudicator.

The review identified that data was not held in line with the PHSO's formal information security policy at the time, and as you know this relates to my offer to NH to use my own email address and mobile telephone number, as had been agreed with the previous ombudsman to offer a friendlier approach. He has then extrapolated this to suggest that his personal data and the private information concerning his deceased daughter was misused and misplaced. This is not correct: the only information that was stored temporarily in this way was supplied by NH himself in emails to me, which he understood were to my personal email address, as was apparent anyway from the address itself. He used this extensively, as well as my mobile number, but all bar a few more trivial emails were then copied by me to the PHSO email system for secure storage.

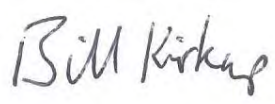
The submission remarks that this "was known about in 2016/7 when senior managers at the PHSO reprimanded an investigator for not following procedures, but nothing was done about it." This is a misrepresentation. In fact, NH had questioned whether some of his previous emails to a former PHSO senior official had been disclosed, and I did receive a letter suggesting he had complained about my use of email. I asked NH about this, which is how he knows of it, and he said that he had not complained about my use of email but the previous issue, and that he welcomed being able to contact me directly and wanted it to continue.

Although it is perhaps a more minor point, he mentions a visit to Newcastle to speak to me. This was at his request, and I believe took place in York, not Newcastle, because he was going to be travelling in the vicinity for another purpose or I would have come to London.

Finally, my recollection of the meeting at the Royal Society of Medicine differs very substantially from the account in the submission. The meeting was undoubtedly tense, because it was clear to all that this would be the final opportunity to consider the disagreements on a minority of the findings, and NH was challenging on occasions, as would be expected. But my clear recollection is that your reaction was dignified, calm and professional at all times. I do not recognise the description he has given.

Please let me know if there is anything further you would like me to clarify or comment on.

Bill Kirkup



Appendix D

Parliamentary and Health Service Ombudsman (PHSO)

Complainant Feedback: Charter Commitment 10

Summary Report of Findings

Parliamentary and Health Service Ombudsman

Opinion Research Services

March 2020

Parliamentary and Health Service Ombudsman (PHSO)

Complainant Feedback: Charter Commitment 10

Summary Report of Findings

Opinion Research Services

The Strand · Swansea · SA1 1AF
01792 535300 | www.ors.org.uk | info@ors.org.uk

This project was carried out in compliance with ISO 20252:2012

Summary of Findings

Background and commission

1.1 In 2016, PHSO published its Service Charter. This was developed in consultation with a wide range of stakeholders including complainants. It consists of a series of commitments that explain what individuals can expect from PHSO when they ask it to look into a complaint.

1.2 Opinion Research Services (ORS) undertakes the PHSO complainants' survey. The survey asks a series of questions designed to assess PHSO's performance against the majority of their Service Charter Commitments. However, commitment 10 (*"we will evaluate the information we've gathered and make an impartial decision on your complaint"*) is not covered as it was thought to be too complex a concept to be effectively assessed via a questionnaire.

1.3 In response to requests from the Public Administration and Constitutional Affairs Committee (PACAC), PHSO have embarked on a programme of qualitative research to explore complainants' perceptions of PHSO's performance in relation to Service Charter Commitment 10.

Overview of the process

1.4 ORS facilitated a focus group on Charter Commitment 10 with complainants in Manchester on 24 September 2019. Subsequently, a series of 25 depth interviews with different complainants were held by ORS to build on the findings from that session.

1.5 For the focus group, a small sample of participants was recruited by telephone from ORS's social research telephone unit having been drawn from a pool of those from the Greater Manchester area who had responded to the complainants' survey and agreed to take part in further research. The group lasted for just over two hours and in total there were seven attendees, all of whom, as standard good practice, were recompensed for their time and efforts in travelling and taking part.

1.6 For the depth interviews, a sample of 25 participants was drawn from a long-list of people who had completed the complainant survey and agreed to be re-contacted for a more in-depth discussion. A cross-section of people were recruited using a recommended distribution table that included: investigation stage; ethnicity; disability; and location. The interviews lasted on average between 20 and 30 minutes.

Key findings

Fairness is seen as an essential component of impartiality

1.7 Participants agreed that although they are different, impartiality and fairness are inextricably linked inasmuch as the latter is a consequence of the former. It is clear then that demonstrating impartiality is very important within an organisation aiming to provide a service that is viewed as fair.

Defining impartiality

Carefully and thoroughly examining both sides is key

1.8 Participants were asked to define what they viewed as impartiality in the context of PHSO complaints. Many stressed that in order for PHSO to demonstrate impartiality (and thus fairness), it must look at both sides of a complaint carefully, thoroughly and objectively - and ensure it gathers and makes use of all relevant information from complainants and the organisations they are complaining about. Not having any preconceived ideas (on either side) until all appropriate facts are gathered was also considered essential.

Demonstrating impartiality in decision-making

A perceived lack of thoroughness can lead to allegations of bias

1.9 Participants said they had initially felt PHSO would take an exhaustive approach to exploring the minutiae of every complaint, but that this had not been the case in reality. Feedback centred around: unasked and unanswered questions; insufficient thoroughness when going through the issues; and important witnesses not being interviewed.

1.10 Furthermore, even where complainants felt their caseworker did the best they could, if they are ultimately unable to gather all relevant information, it was noted that this can also lead to some feeling of impartiality. In this regard, several participants said that the organisation against which they complained had been obstructive, making it difficult for PHSO to investigate as thoroughly as it and the complainant might like.

There is a perception that PHSO sides with organisations and experts

1.11 Participants said that if they feel PHSO has not investigated their complaint or answered their questions sufficiently, this can lead to a perception that it has sided with the organisation being investigated.

1.12 Many participants said they felt PHSO favours organisations on the issues as opposed to complainants. Participants also felt PHSO would place less weight on their views due to their emotional investment in their case. Furthermore, the use of experts during the investigation was thought in itself to contribute to a feeling of imbalance inasmuch as it was felt that the former are unlikely to criticise members of their own profession.

Mismatches between complainants and organisations must be acknowledged

1.13 Several participants described their feeling of a mismatch between the complainant on the one hand and the organisation being investigated on the other - and the neutral role of the Ombudsman within that. Overall, feedback indicated a sense that the two parties enter the process on a wholly unequal footing given the latter has a host of resource and expertise at its disposal that the former does not.

1.14 Given that complainants may have experienced not only an initial traumatic event, but also a frequently lengthy and complex internal complaints process, some said that they are often in a highly emotional and vulnerable state by the time they reach the Ombudsman and are thus unlikely to be able to make their arguments as coherently as they otherwise might. It was suggested that a guide might be useful to assist people through the process of making a complaint in a less emotional way.

1.15 In the context of the above findings, some participants suggested that PHSO's neutral stance reinforces the mismatch between complainant and organisation, and that complainants would be better served by a process that leans slightly in their favour and redresses at least some of the aforementioned (perceived) imbalance.

Demonstrating fairness in decision-making

Good communication is essential, but is sometimes felt to be lacking

1.16 Good communication is considered a key component in effective and fair complaint management, particularly with respect to keeping in touch with a complainant by phone and letter, as well as providing updates when promised. Many participants were happy that their caseworker had communicated with them consistently throughout the case (mainly via email and telephone). Yet others cited a lack of contact as a negative aspect of the investigation process. Primarily, these participants found that PHSO staff did not always get back to them when they said they would or that they had to chase for updates on their case.

There were differences in views on whether PHSO listened to and understood key issues

1.17 There was no clear consensus among participants as to whether PHSO had listened to and understood the key issues they had raised. Some felt their caseworker did the best they could in terms of understanding their complaint – but others felt that this was not the case and said they had not felt listened to or properly understood. Furthermore, even some of those who felt their complaint had been understood at the outset believed the detail of it had either been misinterpreted or ignored subsequently.

1.18 In cases where participants felt their caseworker had not fully understood their complaint and its issues, it was suggested that this may have been because of their lack of specialist (especially medical) knowledge, or apparent difficulties translating theoretical knowledge into an understanding of actual situations.

Being able to ask questions - and have them answered - is important

1.19 Many depth interview participants said they were given the chance to input into questions they would ask of the other party and its experts - and a few stated that PHSO itself asked all the questions it could. However, others said they were not able to put forward specific questions – and that they had expected certain questions to be asked of the organisation against which they were complaining, which were not.

1.20 In terms of participants having their own questions answered, there were a few concerns raised about lack of contact - and a couple of participants claimed to not have received answers to several questions posed to the PHSO, or to have felt their caseworker was in a hurry to close the case without a proper and thorough investigation of all the issues. Participants said this can lead them to view their caseworker as uninformed and give the impression that their investigation was insufficiently thorough.

The reasoning behind decisions and the information used (or not) in reaching them must be carefully explained

1.21 A lack of transparency around explanations as to why certain information has been considered was an issue for some participants. Indeed, being seen as selective around the information being relied on when PHSO makes its decisions can add to complainants' perceptions of bias and unfairness. This is especially true if PHSO does not explain why it has relied on certain pieces of information over others. This feedback suggests that providing explanations as to why certain information has or has not been used in a case may well help individuals overcome their disappointment about an unfavourable decision.

1.22 Participants said that PHSO should be more open in demonstrating it has done everything possible during the investigation stage, including sharing information on the communication between itself and the organisation being complained against - as well as who exactly they have engaged from the 'other side' and why.

Demonstrating empathy and understanding

Empathy and understanding are important in building trust and demonstrating impartiality

1.23 Most participants agreed that their caseworker had taken the time to understand their feelings and demonstrated empathy and understanding. However, a minority described their caseworker as obstructive, absent and lacking in empathy. Several depth interview participants in particular felt that PHSO had not taken their feelings into account and had not listened to the impact their experience had had on them.

Ensuring the human impact of complaints is recognised within the investigation is important

1.24 A small number of participants commented that PHSO appears to focus more on process than human impact, with one person expressing frustration about being told they would be unable to progress their case with the Ombudsman until they had exhausted all avenues with the organisation being complained about.

1.25 Moreover, participants spoke about the length of the process and the bureaucracy involved, which was a frustration for many. Participants also reported frustration around inflexible deadlines and the lack of empathy shown towards people's needs, particularly in relation to times when PHSO was late providing its outputs, but participants were expected to stick to timetable when providing their comments.

A lack of face-to-face contact can contribute to perceptions of a lack of empathy

1.26 Participants felt that a lack of face-to-face interaction during the investigation process can contribute to perceptions of a lack of empathy. There was certainly a feeling that PHSO is too physically distant from complainants, which is an obstacle in terms of empathising with their particular circumstances.

Individual needs must be recognised

1.27 Recognising, understanding and tailoring a service towards people's particular individual needs and abilities (which is linked to ensuring a decision-making process is delivered on a more equal footing) was considered by participants to be essential in demonstrating fairness. In particular, they spoke of how the bureaucratic nature of PHSO's procedures could be a potential issue for vulnerable complainants, especially those with learning disabilities and/or economic difficulties. Participants felt that not taking these factors into account would make the complaints process less impartial and less fair.

Impact and influence

There was a feeling that PHSO needs more powers to enforce its recommendations and bring about real change

1.28 As a final question, participants were asked if they felt PHSO is truly impartial, and for their thoughts on how it could be more so. It was suggested that while the Ombudsman, on the whole, listens to people's complaints and largely tries its best to investigate them on their behalf, it perhaps does not have sufficient resources or powers to properly deal with the tactics and behaviour of those being complained against. Participants felt that often leads organisations to over-refer to the Ombudsman in the knowledge that - even if it rules against them - it has little power to enforce its recommendations.

How best to capture feedback on PHSO's impartiality

1.29 Participants were asked if PHSO should include a question in its survey of complainants to find out if respondents believe PHSO had acted with impartiality. There was no explicit disagreement with this - but

participants highlighted that impartiality is an abstract and subjective concept, and that it may be difficult for PHSO's users to fully get across their views on this subject via a survey. This may indicate that capturing feedback on impartiality from PHSO's service users cannot be done through a single survey question alone.

1.30 In this context though, it is probably worth considering what, for participants, are the key components of impartiality on the part of PHSO. It can be assumed from the findings that these are:

- Being fair and thorough by looking at both side of complaints carefully;
- Gathering all relevant data and using it for cases;
- Treating complainants with compassion, empathy and understanding;
- Having good communications, especially keeping in touch and providing updates
- Listening to key issues and understanding them;
- Giving the option to ask questions and have those questions answered;
- Being transparent about how decisions are reached;
- Not rushing the closure of a case; and
- Taking account of complainant vulnerabilities and making reasonable adjustments.

1.31 It is thus possible that a rounded, balanced assessment of impartiality might be secured by assessing perceptions of how PHSO performed in these areas.

Appendix E

2021-24 Strategy: first draft

Our vision is to be an internationally respected public services ombudsman by providing an independent, impartial and fair complaints resolution service, while using casework to help raise standards and improve public services.

Strategic Objective 1
Improving awareness of our service and access to justice

Outcome

Our independent and impartial service should be accessible and used by those who need it, whatever their personal circumstances. We will help address the power imbalance that can exist between people and state institutions so that even the most vulnerable feel able to raise cases of injustice. We will conduct new activity to understand the barriers to our service and work with a range of organisations to ensure these are removed as far as possible.

The Ombudsman is a crucial part of the wider administrative justice system and we will work with colleagues across the UK and internationally to learn from each other. As we begin publishing more of our casework, we will continue to explore how we can further highlight what we do so people understand the impact we can have for them when things go wrong. We will also explore new ways to build on our publication system to make it as useful as possible for those that access our data and as a tool for improving public services.

We will seek opportunities to make some of the essential legal improvements our service needs, while at the same time continuing to call for a new Public Services Ombudsman Bill. This includes making sure people are able to bring cases to us directly, not just NHS complaints, instead of having to be referred by their local MP.

Objectives for 2021-24 could include:

- Conducting research to better identify those who do not feel able to, or cannot, access our service and understand what would help them do this.
- Offering clear guidance and support to all organisations, particularly those working with the most vulnerable public service users, on how to contact us at the right time using methods that best meet their needs.
- Increasing people's awareness of who we are and what we do so they know how to contact us if they experience a poor service from public bodies.
- Increasing the information we publish and highlighting significant cases to the media and public to help demonstrate our impact.
- Actively highlighting opportunities for Parliament to make essential improvements to our legal framework.

Strategic Objective 2
Delivering a transparent rights-based service that is continuously improving to meet **people's** needs

Outcomes
We will use a range of approaches to meet the different needs of individuals and organisations, focusing on making the right decision at the right time. By developing our digital capability and online presence complainants and organisations we investigate will experience a better and more efficient service. This will include improvements in how we can easily and securely share information about cases.

Our casework will be of consistently high quality, while demonstrating the role the Ombudsman plays in protecting the fundamental rights of those who have suffered injustice. This will build on the approach set out in the Venice Principles, which we will work with colleagues internationally to champion for adoption by the UN.

We will ensure that all our staff are trained and developed to work to the highest standards of complaint handling. The recommendations they make will help support continuous improvement to ensure public bodies learn from mistakes.

Objectives for 2021-24 could include:

- Offering a range of approaches to resolve people's complaints, including early dispute resolution and mediation, as standard in our service
- Demonstrating that the international standards established by the Venice Principles are embedded in how we work.
- Embracing technology to introduce smarter working that helps reduce our office space, travel and consumption of resources, such as paper.
- Improving our digital and technological capabilities, including to allow complainants direct and secure online access to their case information.
- Introducing more effective electronic data transfers with the organisations we investigate to speed up case handling.
- Creating an 'Academy of Learning' to equip staff to do the best possible job for the people we serve based on the quality standards we set.
- Continually improving our recommendations and casework to drive improvements in public services and make people's lives better.
- Improving how we learn from service users about the service we provide.

Strategic Objective 3
Embed a culture of learning from mistakes to improve public services

Outcomes

We want all NHS and government organisations we investigate to work to a consistent and high standard for complainant handling. We want to play our part in creating a culture where frontline complaint handlers are properly valued by their organisations so that complaints from citizens inform learning and continuous improvements to all public services.

The complaint standards we have developed should inform a new approach to complaint handling and need to be fully integrated across public services in our jurisdiction. We want to use them to help professionalise the sector and improve career paths for those that work in it, while also making sure they are valued and respected by the organisations they work in.

Separately, learning from our casework will inform parliamentary scrutiny of public services and enable the public to be demanding of change where failings have occurred. While we will start to publish casework routinely, we will also continue to lay reports before Parliament where we think lessons are not being learned or so further scrutiny can take place.

This will help the Ombudsman, in his role at the end of the complaints system at the UK level and for the NHS in England to fulfil one of his fundamental roles, identifying system-wide improvements to public services. Achieving this should improve the efficiency and effectiveness of public services, while making life better for the people that use them. We will also improve how we use our own data to inform our approach to this systemic work.

Objectives for 2021-24 could include:

- Embedding the standards for public sector and NHS complaint handling we have created in partnership with the public, regulators and other public bodies as well as advocacy and advice providers.
- Continuing developing training to support the delivery of these new complaint standards across organisations in our jurisdiction.
- Developing an independently assured system of training and accreditation to support the professionalisation of complaint handling at all levels across UK parliamentary bodies and the NHS in England.
- Working across the complaint handling system to support clearer routes for career progression for those working in it, including our own staff.
- Continuing to work with regulators, professional bodies and advice and advocacy organisations through sharing findings and the recommendations we make so they can help us improve public services.
- Providing Parliament with the information it needs from casework so that it can examine failings in public services and ensure learning happens.
- Exploring how more sophisticated analysis of data can help us identify trends and thematic issues in casework to inform the recommendations we make for system-wide improvement of public services.

PACAC (Public Administration and Constitutional Affairs Committee)
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Rob Behrens CBE
Parliamentary and Health Service Ombudsman
By email

18th May 2020

Dear Rob,

PHSO scrutiny 2018-19 additional questions

I am grateful to you and Amanda Amroliwala for attending today's Committee meeting scrutinising the work of the PHSO. Time in the evidence session is limited and I have therefore set out some further written questions to which I would be grateful to receive a response.

PHSO annual report and accounts 2018-19 and written evidence

1. Page 34 of your annual report describes the number of days it has taken to close cases. Are these calendar days, or working days? And could this please be clarified in subsequent publications?

2. As explained on page 44, you "invested £353,000 in new ICT capabilities and technical infrastructure". Were there any teething issues with this new ICT provision? And were there any write-offs under this investment?

3. Page 64 of your annual report notes that the Board commissioned an external independent review. What were the main learning points from this review?

4. Page 21 of your annual report describes "maintaining dialogue with....the Public Administration and Constitutional Affairs Committee" about your funding requirements. How do you propose to maintain such a dialogue to keep the Committee informed of your funding requirements? Is there anything of which you need to notify us?

5. In your written evidence, you describe the establishment of a new Expert Advisory Panel, which brings support and challenge to improve the organisation. Could you please provide more information on:
    1. How the panel works in practice, and how the panel brings support and challenge to the PHSO;
    2. how long panel members' tenure lasts; and
    3. whether you have plans to change the panel's membership from time to time, to ensure there is always fresh external challenge.

6. Why does the PHSO use KPMG as its internal auditors, rather than the Government Internal Audit Agency?

Handling of Mr Nic Hart's complaint

7. One of the failures identified in the review concerned handovers between caseworkers. The review notes that guidance says that caseworkers must produce written handover notes before leaving the organisation. What are you doing to ensure that this is done? Also, is it best practice within the PHSO for caseworkers to introduce their successor to complainants to help build trust?

8. Another failure that was highlighted was about communication with Mr Hart. The Committee often receives submissions from the public concerned about the length of time for which they do not receive answers to their correspondence. Does the PHSO have target times to respond to correspondence, and if not, would you agree to include target times for correspondence in your KPIs, along with your Service Charter?

9. Mr Hart described his distress at the misplacing or potential misuse of his personal information and private information about his daughter Averil. Has a full assessment has been made of the risk to Mr Hart's personal data of the failure to follow the PHSO's data security procedures?

10. Mr Hart explained to us that the PHSO failed to assure him that evidence he submitted was given the proper weight. How do the PHSO's caseworkers seek to assure complainants that their evidence has been given proper weight? (For example, is all evidence the complainant submitted commented on, to actively demonstrate it has been considered?)

11. Please could you set out each failing found by the review, the actions proposed to be taken in response (including those that had already been implemented by the time the review was completed) and target dates for completion for any actions still outstanding.

Other matters

12. The Committee has received representations critical of the PHSO's lack of accommodation of complainant's reasonable adjustments. What is the PHSO's policy for complainant's reasonable adjustments? Does the PHSO require complainants to justify their need for reasonable adjustments?

13. In one piece of written evidence, it was suggested to the Committee that the PSHO is not well-equipped to deal with complaints about HS2 ltd. It was put to us that investigations into HS2 require specialist knowledge and a body should be established that can compel HS2 Ltd to "put things right" (rather than simply providing recommendations). What is your response to that?

14. One member of the public, who though not a member of WASPI submitted a complaint to DWP following their advice, has expressed frustration at the ongoing delay in investigating these cases. I note your website states that you cannot provide ongoing commentary as you must investigate in private but are you able to provide any expected timeframe for the six sample complaints to be investigated?

I appreciate there are a number of questions here but I would be grateful nevertheless to receive a response by 5 June.

Yours ever,

William Wragg MP
Chair, Public Administration and Constitutional Affairs Committee