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Public Administration and Constitutional Affairs Committee

Parliamentary and Health Service Ombudsman Scrutiny 2018–19

Second Report of Session 2019–21

Report, together with formal minutes relating to the report

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Public Administration and Constitutional Affairs Committee

The Public Administration and Constitutional Affairs Committee is appointed by the House of Commons to examine the reports of the Parliamentary Commissioner for Administration and the Health Service Commissioner for England, which are laid before this House, and matters in connection therewith; to consider matters relating to the quality and standards of administration provided by civil service departments, and other matters relating to the civil service; and to consider constitutional affairs.

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Committee reports are published on the Committee's website at www.parliament.uk/pacac and in print by Order of the House.

Evidence relating to this report is published on the inquiry publications page of the Committee's website.

Committee staff

The current staff of the Committee are Iwona Hankin (Committee Assistant), Claire Hardy (Committee Specialist), Gabrielle Hill (Senior Committee Assistant), Sarah Ioannou (Second Clerk), Dr Philip Larkin (Committee Specialist), George Perry (Media Officer), Sarah Rees (Clerk), Dr Patrick Thomas (Committee Specialist), Rebecca Usden (Senior Committee Specialist) and Jonathan Whiffing (Second Clerk).

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Summary

The Parliamentary and Health Service Ombudsman (PHSO) is the complaint handler of last resort for individuals who have complaints about public services provided by UK Government Departments and the NHS in England. The Ombudsman is independent of the Government. The Public Administration and Constitutional Affairs Committee (PACAC) scrutinises the reports it lays before Parliament, including its annual report and accounts.

Going forward, PACAC will broadly scrutinise the PHSO under the following headings:

- The PHSO's casework and productivity;
- Staff management;
- Value for money; and
- Impact on other organisations.

We include as an annex a table setting out these areas of scrutiny and the sort of evidence we would expect to consider against each heading.

While the PHSO has met its section KPI scores, there are some concerning scores from complainant feedback, such as relating to gathering evidence and explaining how it makes decisions and recommendations and these should be priority areas for improvement and we will monitor this closely in future scrutiny sessions. The Committee will be particularly interested in the PHSO's changes to its commissioning and handling of clinical advice, and whether these changes improve feedback from those who use the Ombudsman.

The PHSO's senior management have done a good job to improve staff engagement scores as measured staff survey results, especially considering the level of change the organisation has recently undergone. PACAC encourages the PHSO to build on these results and seek to become a high performer in that survey.

The PHSO has achieved significant savings in a short amount of time as part of the 2015 Spending Review but there is now a need for a serious discussion on the level of funding the PHSO requires to fulfil its ambition to become an exemplary ombudsman. PACAC would support an evidenced-based bid for funding if it was demonstrated that this would improve service to complainants.

It is important that the PHSO demonstrates its recommendations have impact in improving the services that it investigates. As part of this work, the PHSO should include information about organisations' compliance with their recommendations in its annual report. The PHSO should seek to strengthen its relationship with Select Committees of the House and provide information on findings they have made against Government

Departments to help inform Committees' scrutiny of those Departments.

1 Public Administration

The Parliamentary and Health Service Ombudsman

1. The Parliamentary and Health Service Ombudsman (PHSO) combines the statutory roles of Parliamentary Commissioner for Administration and Health Service Commissioner for England.[1] As such the Ombudsman adjudicates on complaints that have not been resolved by the NHS in England and UK Government Departments. The post is currently held by Rob Behrens, who is "the Ombudsman". There are separate ombudsman arrangements for local government services in England and for public services provided by the devolved governments.

2. The Ombudsman is independent of the Government, the NHS and Parliament. However, it is accountable to Parliament, through the Public Administration and Constitutional Affairs Committee (PACAC), for the overall performance of the PHSO and for its use of resources.[2] This has traditionally been through an annual evidence session based on the PHSO annual report and accounts. The Committee does not inquire into individual cases. However, the Ombudsman can lay reports before Parliament, often to highlight cases that he decides raise issues of wider concern, which PACAC (or another select committee) may then scrutinise. An example of such a report was the *Missed opportunities* report.[3]

3. The annual scrutiny session for 2018–19 was delayed ahead of the 2019 General Election. The Committee held an oral scrutiny session on 18 May with the Ombudsman and Amanda Amroliwala, the Chief Executive Officer and Deputy Ombudsman.

4. This report sets out the Committee's conclusions from both that evidence session and the written submissions it has received. As part of their submissions, many witnesses have described times of great personal and family pain, difficulty and bereavement. We are very grateful to everyone who submitted written evidence.

Our approach to scrutinising the PHSO

5. Going forward the Committee intends to scrutinise the PHSO consistently in the following areas:

- casework and productivity;
- staff management;
- value for money; and
- impact on other organisations.

A table, setting out the areas the Committee plans to scrutinise over the course of the Parliament, is appended to this report. However, the Committee will maintain flexibility to consider emerging matters of importance each year.

1 Parliamentary and Health Service Ombudsman, "Who we are" accessed 27 May 2020
2 Standing Orders (Public Business) 5 November 2019, HC 314
3 Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust, Parliamentary and Health Service Ombudsman, 11 June 2019

2 The PHSO's casework and productivity

6. At its core, the PHSO is a complaints investigation and handling body. Its performance in producing high quality investigations and reports, which can command the confidence of both the complainant and organisation complained about, is therefore essential. In this chapter we consider the following evidence of the PHSO's casework performance:

- Responses from complainants to the PHSO Service Charter and written evidence received from complainants.
- The time taken to close cases.
- The report on the PHSO's review into their handling of Mr Nic Hart's complaint.

Quality of casework

7. The Committee does not look at individual cases and its scrutiny in relation to the quality of PHSO casework is primarily based on the results of the PHSO performance against its KPIs under its Service Charter and the written evidence received from complainants. Common concerns that have been raised include:

- The quality of medical advice relied upon by the PHSO.[4]
- Concerns the PHSO did not take account of all the evidence the complainant had provided, or that the PHSO was biased in favour of the organisation complained about.[5]
- The time taken to complete investigations.[6]

The PHSO's KPIs

8. The tables below set out the PHSO's performance against its three sections of KPIs. This includes both the score from complainant feedback and the PHSO's own internal casework assurance process:

Table 1: PHSO Key performance indicators–"giving you the information you need" (section target: 75%. Overall Complainant section score: 79%)

KPI	2018–19 complainant score	2018–19 average internal casework assurance score[7]
1. We will explain our role and what we can and cannot do	79%	99%
2. We will explain how we handle complaints and what information we need from you	80%	99%

4 See for example: Nic Hart, (HOS0033)
5 See for example: A2, (HOS0010)
6 See for example: Nic Hart, (HOS0033); Margaret Whalley, (HOS0017)
7 Averaged from quarterly data sets under the PHSO's Service Charter

KPI	2018–19 complainant score	2018–19 average internal casework assurance score[7]
3. We will direct you to someone who can help with your complaint if we are unable to, where possible	78%	99%
4. We will keep you regularly updated on our progress with your complaint	81%	83%

Source: Parliamentary and Health Service Ombudsman Annual Report and Accounts 2019–20

Table 2: PHSO Key performance indicators–"following a fair and open process" (section target: 65%. Overall Complainant section score: 68%)

KPI	2018–19 complainant score	2018–19 average casework assurance score
5. We will listen to you to make sure we understand your complaint	73%	97%
6. We will explain the specific concerns we will be looking into	88%	93%
7. We will explain how we will do our work	77%	83%
8. We will gather information we need, including from you and the organisation you have complained about, before we make our decision	48%	99%
9. We will share facts with you and discuss with you what we are seeing	68%	45%
10. We will evaluate the information we have gathered and make an impartial decision on your complaint	-[8]	98%
11. We will explain our decision and recommendation and how we reached them.	53%	99%

Source: Parliamentary and Health Service Ombudsman Annual Report and Accounts 2019–20

8 The PHSO has does not yet track and publish this figure.

Table 3: PHSO Key performance indicators–"following a fair and open process" (section target: 67%. Overall Complainant section score: 70%)

KPI	2018–19 complainant score	2018–19 average casework assurance score
12. We will treat you with courtesy and respect	90%	-
13. We will give you a final decision on your complaint as soon as we can	53%	58%
14. We will explain how we will do our work	67%	96%

Source: Parliamentary and Health Service Ombudsman Annual Report and Accounts 2019–20

Following a fair and open process

9. The PHSO scored just 48% from complainant feedback on gathering all the information it needs before making a decision, and 53% for explaining how the PHSO has reached its decisions and recommendations. In oral evidence Amanda Amroliwala said she was not "satisfied" with these scores and accepted there was a need "to continue to get better".[9] Despite this, the PHSO's own internal casework assurance process averaged 99% against these KPIs.

10. Amanda Amroliwala further explained that the PHSO had invested in training its staff in communication skills, noting in particular that in some medical cases the PHSO deals with some "very complex medical information".[10] One of the things the PHSO has recently done is publish a guidance document for caseworkers setting out how it uses and weighs evidence.[11]

11. **The Committee welcomes the fact that the PHSO has met its target KPI scores against each section in its Service Charter.**

12. **Notwithstanding the fact the PHSO has met its section average KPI scores, there are some particularly disappointing scores relating to gathering information and explaining how it makes decisions and recommendations. There is also a significant gap between the scores from complainant feedback and the PHSO's own internal assurance scores for these KPIs. It is essential that complainants feel the PHSO has gathered and used the evidence correctly if they are to have confidence in the outcome of the PHSO's investigations, and these scores indicate serious dissatisfaction among a significant number of complainants. The Committee welcome the PHSO's publication of the guidance on how caseworkers should use and weigh evidence. *This should be a priority area for improvement for the PHSO who should report back to the Committee with the actions it is taking to improve these scores and the results of those actions. This report should also highlight any similarities between the types of cases that seem to consistently attract low scores. The PHSO should also review its internal assurance procedures to narrow the gap between complainant scores and the internal assurance scores.***

9 Qqs 12 and 14
10 Q12
11 Guidance for Balancing Evidence, Parliamentary and Health Service Ombudsman, accessed 9 June 2020

The time taken to close cases

13. The PHSO's written evidence further contends that it is "closing enquiries and complaints more quickly. In 2018–19 it took us an average of 158 days to close a case. From April to December 2019–20, we closed cases in an average of 140.8 days."[12] However, this performance nonetheless represents an increase in the average time to close cases, as it took 135 days in 2016–17 and 132 days in 2017–18. These numbers do not include the cases that are closed within seven days by the PHSO's helpline.[13] The PHSO's annual report suggests this is because there was a backlog of 1,000 complaints at the beginning of the year and that "despite improving the response times for a high proportion of complainants this year, we saw the average time it takes to close complaints increase and a negative impact on our performance against our key performance indicators".[14]

14. In oral evidence Amanda Amroliwala, Chief Executive and Deputy Ombudsman of the PHSO, explained that the PHSO does not have a set time for closing cases, as it had adopted a policy of "right decision, right time". but rather:

> We also have a set of indicators that are common across public service ombudsmen that say for ourselves our first indicator is that we will try to complete 50% of our casework within 13 weeks—so within about three months—and we will aim to complete 75% within six months and then 95% within 12 months, recognising that some very complex cases will take longer than that.[15]

15. In 2018–19 the PHSO's performance against those timeframes were as follows:

Table 4: Time taken to close cases

Timeframe	Target % of cases	Actual % of cases	Difference between target and actual %
13 weeks	50%	39%	-11%
26 weeks	75%	71%	-4%
52 weeks	95%	91%	-4%

Source: Parliamentary and Health Service Ombudsman Annual Report and Accounts 2018–19, pg 33

16. The importance of timely investigations and reports was made clear to us in written evidence. Nic Hart argued that, had the PHSO's investigation into the death of his daughter been concluded more swiftly and effectively, further deaths from similar failings in care could have been avoided.[16] Margaret Whalley argued that recommendations from prolonged investigations lack the same impact of investigations conducted in a timely fashion.[17] Feedback from complainants, as demonstrated by the PHSO's service charter, showed just 53% of complainants believed that the PHSO gave a final decision on their complaint as soon as they possibly could[18] (compared to the PHSO's internal casework assurance score of 58% for 2018–19.)[19]

12 Ibid
13 Parliamentary and Health Service Ombudsman Annual Report and Accounts 2019–20, p32
14 Ibid, p33
15 Q17
16 Nic Hart, (HOS0033)
17 Margaret Whalley, (HOS0017)
18 Parliamentary and Health Service Ombudsman Annual Report and Accounts 2019–20, p40, KPI 13
19 Parliamentary and Health Service Ombudsman, Performance Against our Service Charter, Accessed 1 June 2020

17. The PHSO's written evidence explains that from April to December 2019 the situation has improved, with 50.3% of cases closed within 13 weeks and 79.7% closed within 26 weeks.[20]

18. **There are clear advantages to PHSO investigations being conducted in an efficient fashion, such as recommendations being timelier, which can in turn help prevent similar scenarios from reoccurring. The Committee is pleased to hear that the PHSO has cleared its backlog and that the time taken for complaints to be resolved appears to have fallen in 2019–20. This is something the Committee will monitor for the next scrutiny session.**

The impact of Covid-19

19. Rob Behrens wrote to the Committee on 23 March 2020 to explain that, as a result of Covid-19 and in order to prevent adding further pressure on the NHS system and divert resources from the frontline, the PHSO had taken the decision to temporarily pause existing NHS complaints and stop accepting new complaints. Mr Behrens subsequently wrote to us on 12 June 2020 to explain that the PHSO investigations of NHS complaints would be reopening on 1 July.[21]

20. **The PHSO's decision to pause NHS complaints as a result of Covid-19 was a reasonable immediate reaction. However, this is not a long-term sustainable position, as there is a risk of a backlog of cases developing, which could leave complainants seeing longer periods of stress and uncertainty and may serve to distort the PHSO performance in terms of completed cases in a satisfactory amount of time. *The PHSO should ensure that its reporting on the time taken to complete cases is not distorted and may need to compensate with extra information in its 2020–21 annual report, for example, by publishing further information on the time taken to complete NHS cases that do not include the time lost to Covid-19. This will present a clearer picture of the PHSO's productivity.***

The handling of Nic Hart's complaint

21. The PHSO published a review of its handling of Nic Hart's complaint on the death of his daughter Averil Hart.[22] The review was led by "a manager in PHSO's senior leadership team. This manager was not employed by PHSO at any point during PHSO's handling of Mr Hart's complaint."[23] The review accepts a number of failures in the PHSO's handling of Mr Hart's complaint, including:

- The time taken to close the case—the case took nearly three years and four months to conclude.
- The resourcing of the case—there was not a clear and consistent plan in place to resource the investigation.

20 Parliamentary and Health Service Ombudsman, (HOS0022)
21 Correspondence dated 23.03- 12.06 with Rob Behrens, Parliamentary and Health Service Ombudsman.
22 Report of a review into the Parliamentary and Health Service Ombudsman's handling of Mr Nic Hart's case from August 2014 to December 2017, Parliamentary and Health Service Ombudsman
23 Ibid

- Communication with the complainant—five caseworkers worked on the case at different times, which meant that Mr Hart had to build new relationships and re-tell his story to multiple caseworkers.
- Appointment of an external investigator—an external investigator was appointed, but their role and responsibilities were not clearly communicated to Mr Hart, leading to confusion.
- Decision-making—several changes were made to the PHSO's approach to the investigation, causing confusion to Mr Hart about what the PHSO was doing and why.
- Use of evidence—the PHSO failed to explain to Mr Hart how his evidence was used or to assure him it was given proper weighting.

22. As a result of these errors, the PHSO has sincerely apologised to Mr Hart.[24] In evidence to us Mr Hart described the impact these failings had on him, which were not insignificant.[25]

23. **As the PHSO's report into Nic Hart's case acknowledges, there were multiple failures in the PHSO's handling of Nic Hart's complaint and the Committee finds these failures extremely concerning. The report vividly demonstrates the scale of the serious problems that the PHSO was struggling with when Rob Behrens took up his post.**

24. In an annex to a follow-up letter sent after the oral evidence session, the PHSO set out the actions they had taken since Mr Hart's complaint to improve processes and prevent a similar case from reoccurring.[26]

25. **The Committee supports the improvements that the PHSO has implemented to prevent similar failures as that encountered by Nic Hart. In particular, it will revisit the PHSO's changes to how it commissions and uses clinical advice in future scrutiny sessions, as this is particularly important considering that NHS cases take up the majority of the PHSO's caseload. The PHSO must learn the lessons from Mr Hart's case and ensure that these mistakes are not repeated.**

Changes to the commissioning of clinical advice

26. The majority of the PHSO's casework consists of handling health complaints.[27] It is therefore axiomatic that the PHSO's processes for commissioning and using clinical advice need to be robust. Last year the PHSO published a review into its use of clinical advice, 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.[28]

24 Ibid
25 Nic Hart, (HOS0033)
26 Correspondence dated 18.05- 5.06 with Rob Behrens, Parliamentary and Health Service Ombudsman, Appendix A.
27 Parliamentary and Health Service Ombudsman Annual Report and Accounts 2019–20, p 28
28 Our response to the Clinical Advice Review, Parliamentary and Health Service Ombudsman

27. The PHSO has implemented several changes to its clinical advice procedures, including:

- Introducing a more effective relationship between the case handler and the clinical adviser, such as by allowing clinical advisers to see provisional and final reports to ensure their views are properly reflected.[29]
- The introduction of clear procedures when the PHSO receives contradictory clinical advice. In such cases, the PHSO's lead clinician will provide advice on what steps should be taken, such as giving clinical advisers sight of each other's views.[30]
- There is now peer review of clinical advice for more complex cases and, "in exceptional circumstances, PHSO will seek evidence from an additional clinical adviser who can offer a fresh perspective."[31]

28. Amanda Amroliwala indicated the PHSO's intention to conduct a follow-up review-at the end of the PHSO's two year programme to implement the review's recommendations.[32]

29. **The changes to processes for commissioning and using clinical advice were clearly necessary. *The Committee recommends that the PHSO closely monitors and reports back on the effectiveness of the changes to clinical advice. A further follow-up review should be commissioned at the end of the two year implementation period, and again this should be overseen by an independent expert adviser.***

29 Q23
30 Correspondence dated 18.05- 5.06 with Rob Behrens, Parliamentary and Health Service Ombudsman, Appendix A.
31 Ibid
32 Q25

3 Staff management

Staff engagement score

30. The PHSO takes part in the Civil Service People Survey, which forms a convenient evidence base to scrutinise the PHSO's staff management. Amanda Amroliwala described looking at the PHSO's staff survey results in 2016 as "some of the worst scores that I had seen in a public service organisation".[33] In 2016 the PHSO's staff engagement score was just 52%.[34] More recent staff surveys have demonstrated significant improvement. The staff engagement score in 2018 and 2019 was 67% and 65% respectively, which are both above the survey benchmark.[35] Rob Behrens told the Committee:

> To me, and I am not overconfident on these things, the survey results represent since 2015–16 a cultural transformation of the office, which needs to be put on the record. For example, the confidence of the office in the Ombudsman and the Chief Executive having a clear vision for direction of PHSO was at 23% in 2016 and is at 77% in 2019. I understand that confidence in the aims and objectives of PHSO was less than 50% in 2016. It is now at 85%. There is evidence in the survey that senior managers are open and approachable, almost double the extent they were in 2015–16. This is not to say that everything is right, but it does represent an absolute transformation in the views of staff.[36]

31. **The senior management of the PHSO has done a good job to create a sustained and substantial improvement in the staff engagement score, particularly given the scale of change the organisation has recently undergone. The Committee will continue to follow the PHSO's performance as part of the Civil Service People Survey and would encourage the organisation to build upon these scores to become a high performer in that survey.**

32. The PHSO matches or outperforms the survey benchmark in all categories with except for "resources and workload" (73% vs 74%) and "learning and development" (45% vs 54%). The Learning and Development score has fallen compared to 2018, by three points (from 48% to 45%).[37] This reduction comes even though, as per the PHSO's written submission, staff received 2,315 days of training.[38]

Staff training

33. In oral evidence, Amanda Amroliwala explained that the Learning and Development scores were disappointing given the PHSO's investment in training, but stressed that the score for delivery of training and development have increased.[39] Staff training is important because, as Rob Behrens noted, PHSO staff have an "immensely difficult job".[40]

33 Q31
34 Employee Survey Presentation of Results to Staff November 2016, Parliamentary and Health Service Ombudsman
35 Parliamentary and Health Service Ombudsman Civil Service People Survey 2019
36 Q35
37 Parliamentary and Health Service Ombudsman Civil Service People Survey 2019
38 Parliamentary and Health Service Ombudsman, (HOS0022)
39 Q32
40 Q2

34. The table below sets out the scores the PHSO received under learning and development.

Table 5: PHSO staff survey learning and development scores

Question	Positive response (%)	Difference from previous survey	Difference from CS2019[41]
I am able to access the right learning and development opportunities when I need to	61	+7	-3
Learning and development activities I have completed in the past 12 months have helped to improve my performance	52	-3	-2
There are opportunities for me to develop my career in PHSO	35	-11	-16
Learning and development activities I have completed while working for PHSO are helping me to develop my career	33	-6	-17

Source: Parliamentary and Health Service Civil Service People Survey 2019

35. **The Learning and Development scores are disappointing considering the PHSO's investment in training, particularly a positive response of just 52% to the statement "Learning and development activities I have completed in the past 12 months have helped to improve my performance", which represents a reduction of 3% from the previous year.** ***The Committee recommends that the PHSO carries out more analysis into these results, including consulting staff directly, to understand why these scores are low and what training staff feel is needed. The PHSO should report its findings to the Committee, alongside an action plan for improvement before the next survey.***

41 The CS2019 benchmark is the median percent positive across all Civil Service organisations that participated in the 2019 Civil Service People Survey, where data was not suppressed.

4 Value for money

36. In November 2018, an independent peer review of the PHSO concluded that the PHSO had "moved out of critical care and into recovery" and was "on its way to becoming a more efficient and effective organisation, having made significant improvements in management systems, casework processes, and training and development for staff".[42]

37. Rob Behrens confirmed his intention to commission another value for money study before the end of his term as Ombudsman. In response to previous concerns about the independence of this peer review, Rob Behrens explained that in future the International Ombudsman Institute will validate the membership of peer reviews.[43]

38. **The Committee welcomes the Ombudsman's commitment to commission another value for money study during the remainder of his term and is pleased that the International Ombudsman Institute will validate the membership of future peer reviews.** ***The value for money studies should provide assurance on the quality of the PHSO's casework, by comparing it with best practice in the Ombudsman sector.***

39. One point of praise from the peer review was the quality of data provided by the PHSO's Service Charter. As explained in chapter 2, the Service Charter contains commitments from the PHSO, against which the PHSO reports feedback from complainants and, more recently, the organisations complained about.[44]

40. **The Committee believes that the PHSO's service charter provides robust data about the PHSO's performance, which helps to assess the organisation's value for money and thereby supports the PHSO's move to also collect feedback against the Service Charter from the organisation being complained about.** ***The PHSO should also include casework assurance scores against the Service Charter in its Annual Report.***

PHSO funding requirements

41. As part of the 2015 Spending Review, the PHSO committed to reducing its costs by 24%. According to the PHSO's written evidence it has "successfully delivered this commitment, having achieved over £6.5million in savings between 2016–17 and 2018–19". This included actions such as moving most of the Ombudsman's operational delivery from London to Manchester.[45]

42. In oral evidence, Rob Behrens requested the Committee's support in seeking greater funding for the PHSO, noting that "money isn't everything but that is an issue in terms of the ambition we have to make us into a world-class ombudsman service."[46] The AEA Technology Pensions Campaign argued that the PHSO's resources should be increased in

42 Peter Tyndall, Caroline Mitchell, and Chris Gill "Value for Money Study: Report of the independent peer review of the Parliamentary and Health Service Ombudsman" 12 November 2018, para 10.1
43 Q46
44 Performance against our service charter, Parliamentary and Health Service Ombudsman, accessed 9 June 2020
45 Parliamentary and Health Service Ombudsman, (HOS0022)
46 Q2

order to improve the quality of the PHSO's service.[47] In a follow-up letter, Rob Behrens explained that the PHSO was awaiting information from "HM Treasury about what process they will be running for the next Comprehensive Spending Review".[48]

43. **The PHSO successfully delivered cost reductions of 24% in a short amount of time. There is, however, a need for a serious discussion about the level of funding the PHSO requires to sustainably deliver a good service and become an exemplary Ombudsman.** ***Ombudsman services serve as a last point of appeal for complaints from people who have suffered great distress or loss. It is essential that such services are properly resourced. The Committee would support an evidence-based bid for more funding if it could be demonstrated that this would improve service to complainants. The PHSO should prepare this evidence ahead of the now-postponed Spending Review and keep the Committee fully informed of its funding requirements and the implications of the eventual settlement.***

The need for legislation

44. In previous Parliaments, the predecessor Committee consistently called for modernising legislation to bring the PHSO in-line with best practice.[49] Rob Behrens described the PHSO's legislation as being "lightyears" behind European countries.[50] Issues with the PHSO's legislation include:

- Lack of own initiative powers.
- The need to unite the PHSO and the Local Government and Social Care Ombudsman into a single Ombudsman.
- Not being a complaints standards authority.
- The "MP Filter".

Lack of own initiative powers

45. Rob Behrens explained that other Ombudsmen were able to uncover failures "particularly in areas in which people do not complain".[51] An example of the effect of this in England was the Ombudsman's *Missed Opportunities* report.[52] For that case the PHSO investigated the deaths of two young men in mental health institutions. However, the lack of own initiative powers meant that the PHSO could only look at the two complaints they had received and couldn't look at similar cases that had taken place within the Trust. Rob Behrens asserted that, with own-initiative powers, this process would been a more cost-effective and value for money way of dealing with the issue.[53]

47 Dr Tony Wickett, (HOS0018)
48 Correspondence dated 18.05- 5.06 with Rob Behrens, Parliamentary and Health Service Ombudsman
49 Public Administration and Constitutional Affairs Committee, Sixteenth Report of Session 2017–19, PHSO Annual Scrutiny 2017/18: Towards a Modern and Effective Ombudsman Service, HC 1855
50 Q49
51 Ibid
52 Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust, Parliamentary and Health Service Ombudsman, 11 June 2019
53 Q49

The need to unite the PHSO and the Local Government and Social Care Ombudsman

46. In written evidence, the PHSO explained that:

> Both PHSO and the Local Government and Social Care Ombudsman want to see our two Ombudsman services replaced with a single Public Service Ombudsman, with an integrated jurisdiction across health, social care, local government, UK Government departments and other public services. This would make the complaints process easier for complainants and organisations we investigate, and provide better value-for-money for the taxpayer.[54]

47. This is not simply a technical point; there are difficulties with the present arrangement. For example, in the context of Covid-19, there has been a lot of scrutiny of the seriousness of the treatment of care homes compared with health service issues. While in European countries this is dealt with by a single Ombudsman, in this country there is a split between Ombudsman responsibility for investigating health and social care issues.[55]

Complaints standards authority powers

48. Although at the time of writing the PHSO was in the process of publishing a Complaints Standards Framework for consultation that will be for use across the NHS and, later, other public services, the PHSO does not have powers to set standards for complaints handling nor can it take action against organisations who do not meet particular standards for complaints handling.[56]

The "MP Filter"

49. If Members of the public wish to bring complaints to the PHSO about a Government department or agency, they must do so by having their case referred to the PHSO by their MP. A referral is not required if the complaint is about NHS services. Rob Behrens argued that, in keeping with the Venice Principles for Ombudsman Services, citizens should have direct access to the Ombudsman.[57]

The draft legislation

50. A draft Public Service Ombudsman Bill, that would solve some of the problems mentioned above, was published by the Government in December 2016.[58] Unfortunately substantive progress has not been made on that Bill and the PHSO argues that the draft Bill no longer represents international best practice in Ombudsman sector.[59]

51. ***The Committee repeats its predecessor Committee's calls for modernising legislation, which is plainly necessary to improve the effectiveness and value for money of the Parliamentary and Health Service Ombudsman. The Government should start the***

54 Parliamentary and Health Service Ombudsman, (HOS0022)
55 Q51
56 Parliamentary and Health Service Ombudsman, (HOS0022)
57 Q51
58 Draft Public Service Ombudsman Bill, December 2016, Cm 9374
59 Parliamentary and Health Service Ombudsman, (HOS0022)

legislative process anew with an updated draft Bill for consultation and pre-legislative scrutiny. As part of such legislative reform, the PHSO and the Local Government and Social Care Ombudsman should be replaced with a single Public Service Ombudsman.

52. **While the Committee accepts there are some good reasons for removing the "MP filter" to bring complaints to the PHSO about government departments and agencies, Members of Parliament play a vital role in supporting their constituents' complaints. Therefore, a role for MPs to support their constituents must remain in any substantive legislative reform.**

5 Impact on other organisations

53. One of the ways in which the Committee plan to scrutinise the PHSO going forward is the impact it has on other organisations through its investigations, recommendations and insight reports, this includes:

- Evidence the PHSO ensures its recommendations are taken seriously and implemented.
- The effectiveness of the PHSO's Complaints Standards Framework.

Follow-up of recommendations

54. As part of investigations into complaints it receives, the PHSO may make recommendations to organisations on how they should improve their services. In 2018–19, the PHSO made 1,408 recommendations.[60] In relation to following up on recommendations to ensure compliance, Amanda Amroliwala said:

> Once we have reported, we follow up with those bodies and see whether they have followed through with those recommendations. For some things like apologies or financial payments, we can check that those have happened. Where people are putting in place a long-term programme of change activity or service improvements, it is not our role. We are not a regulator. We are not able to go in and determine whether those have been followed through. We provide copies of our recommendations to the Care Quality Commission, and the Care Quality Commission has the opportunity in its inspections of those bodies, if they are health bodies, to see whether recommendations that are more systemic in nature and long-term have been followed through.[61]

55. **As part of future scrutiny of the PHSO, the Committee will seek evidence that the PHSO has followed up on recommendations to ensure organisations are compliant with their recommendations. In cases in which it would not be appropriate for the PHSO to follow up on recommendations, the PHSO should ensure relevant bodies have been informed about their recommendations and the level of compliance with those recommendations.** ***The PHSO should include compliance information in its Annual Reports and should set out the steps it has taken to maximise compliance with, and impact of, its reports. As part of this work, the PHSO should strengthen its relationships with Departmental Select Committees, especially at official level. Select Committees would benefit from learning about findings against Departments ahead of sessions with Permanent Secretaries on the annual reports and accounts.***

Complaints Standards Framework

56. As set out in Chapter 4, at the time of writing the PHSO was preparing to publish their consultation on a Complaints Standards Framework. The PHSO identified a need for this framework as a result of feedback from complaints handlers that there was no shared

60 Parliamentary and Health Service Ombudsman, (HOS0022)
61 Q36

view of "what good complaint handling looks like"[62] Rob Behrens explained that he saw a "strategic problem" in the PHSO receiving 120,000 enquiries a year "most of which are not within our jurisdiction because they have not been addressed by the frontline body in the first place, so we cannot look at it. It would be much better if the frontline bodies resolved cases effectively so that cases did not come to us unless they were difficult and contentious, so that people knew where they could go in order to address the issues that they have."[63]

57. **There are obvious advantages to improving complaints handling by frontline bodies. If people are satisfied with the way their complaint has been handled in the first instance, this means they will feel they have had a more efficient resolution to their complaint and they will be less likely to pursue a complaint with the PHSO. *The Committee supports the PHSO's work on the Complaints Standards Framework and will seek an update at the next scrutiny session on how that framework is received and how its effectiveness is being monitored.***

62 Parliamentary and Health Service Ombudsman, (HOS0022)
63 Q45

Conclusions and recommendations

The PHSO's casework and productivity

1. The Committee welcomes the fact that the PHSO has met its target KPI scores against each section in its Service Charter. (Paragraph 11)

2. Notwithstanding the fact the PHSO has met its section average KPI scores, there are some particularly disappointing scores relating to gathering information and explaining how it makes decisions and recommendations. There is also a significant gap between the scores from complainant feedback and the PHSO's own internal assurance scores for these KPIs. It is essential that complainants feel the PHSO has gathered and used the evidence correctly if they are to have confidence in the outcome of the PHSO's investigations, and these scores indicate serious dissatisfaction among a significant number of complainants. The Committee welcome the PHSO's publication of the guidance on how caseworkers should use and weigh evidence. *This should be a priority area for improvement for the PHSO who should report back to the Committee with the actions it is taking to improve these scores and the results of those actions. This report should also highlight any similarities between the types of cases that seem to consistently attract low scores. The PHSO should also review its internal assurance procedures to narrow the gap between complainant scores and the internal assurance scores.* (Paragraph 12)

3. There are clear advantages to PHSO investigations being conducted in an efficient fashion, such as recommendations being timelier, which can in turn help prevent similar scenarios from reoccurring. The Committee is pleased to hear that the PHSO has cleared its backlog and that the time taken for complaints to be resolved appears to have fallen in 2019–20. This is something the Committee will monitor for the next scrutiny session. (Paragraph 18)

4. The PHSO's decision to pause NHS complaints as a result of Covid-19 was a reasonable immediate reaction. However, this is not a long-term sustainable position, as there is a risk of a backlog of cases developing, which could leave complainants seeing longer periods of stress and uncertainty and may serve to distort the PHSO performance in terms of completed cases in a satisfactory amount of time. *The PHSO should ensure that its reporting on the time taken to complete cases is not distorted and may need to compensate with extra information in its 2020–21 annual report, for example, by publishing further information on the time taken to complete NHS cases that do not include the time lost to Covid-19. This will present a clearer picture of the PHSO's productivity.* (Paragraph 20)

5. As the PHSO's report into Nic Hart's case acknowledges, there were multiple failures in the PHSO's handling of Nic Hart's complaint and the Committee finds these failures extremely concerning. The report vividly demonstrates the scale of the serious problems that the PHSO was struggling with when Rob Behrens took up his post. (Paragraph 23)

6. The Committee supports the improvements that the PHSO has implemented to prevent similar failures as that encountered by Nic Hart. In particular, it will

revisit the PHSO's changes to how it commissions and uses clinical advice in future scrutiny sessions, as this is particularly important considering that NHS cases take up the majority of the PHSO's caseload. The PHSO must learn the lessons from Mr Hart's case and ensure that these mistakes are not repeated. (Paragraph 25)

7. The changes to processes for commissioning and using clinical advice were clearly necessary. *The Committee recommends that the PHSO closely monitors and reports back on the effectiveness of the changes to clinical advice. A further follow-up review should be commissioned at the end of the two year implementation period, and again this should be overseen by an independent expert adviser.* (Paragraph 29)

Staff management

8. The senior management of the PHSO has done a good job to create a sustained and substantial improvement in the staff engagement score, particularly given the scale of change the organisation has recently undergone. The Committee will continue to follow the PHSO's performance as part of the Civil Service People Survey and would encourage the organisation to build upon these scores to become a high performer in that survey. (Paragraph 31)

9. The Learning and Development scores are disappointing considering the PHSO's investment in training, particularly a positive response of just 52% to the statement "Learning and development activities I have completed in the past 12 months have helped to improve my performance", which represents a reduction of 3% from the previous year. *The Committee recommends that the PHSO carries out more analysis into these results, including consulting staff directly, to understand why these scores are low and what training staff feel is needed. The PHSO should report its findings to the Committee, alongside an action plan for improvement before the next survey.* (Paragraph 35)

Value for money

10. The Committee welcomes the Ombudsman's commitment to commission another value for money study during the remainder of his term and is pleased that the International Ombudsman Institute will validate the membership of future peer reviews. *The value for money studies should provide assurance on the quality of the PHSO's casework, by comparing it with best practice in the Ombudsman sector.* (Paragraph 38)

11. The Committee believes that the PHSO's service charter provides robust data about the PHSO's performance, which helps to assess the organisation's value for money and thereby supports the PHSO's move to also collect feedback against the Service Charter from the organisation being complained about. *The PHSO should also include casework assurance scores against the Service Charter in its Annual Report.* (Paragraph 40)

12. The PHSO successfully delivered cost reductions of 24% in a short amount of time. There is, however, a need for a serious discussion about the level of funding the PHSO requires to sustainably deliver a good service and become an exemplary Ombudsman. *Ombudsman services serve as a last point of appeal for complaints*

from people who have suffered great distress or loss. It is essential that such services are properly resourced. The Committee would support an evidence-based bid for more funding if it could be demonstrated that this would improve service to complainants. The PHSO should prepare this evidence ahead of the now-postponed Spending Review and keep the Committee fully informed of its funding requirements and the implications of the eventual settlement. (Paragraph 43)

13. *The Committee repeats its predecessor Committee's calls for modernising legislation, which is plainly necessary to improve the effectiveness and value for money of the Parliamentary and Health Service Ombudsman. The Government should start the legislative process anew with an updated draft Bill for consultation and pre-legislative scrutiny. As part of such legislative reform, the PHSO and the Local Government and Social Care Ombudsman should be replaced with a single Public Service Ombudsman.* (Paragraph 51)

14. While the Committee accepts there are some good reasons for removing the "MP filter" to bring complaints to the PHSO about government departments and agencies, Members of Parliament play a vital role in supporting their constituents' complaints. Therefore, a role for MPs to support their constituents must remain in any substantive legislative reform. (Paragraph 52)

Impact on other organisations

15. As part of future scrutiny of the PHSO, the Committee will seek evidence that the PHSO has followed up on recommendations to ensure organisations are compliant with their recommendations. In cases in which it would not be appropriate for the PHSO to follow up on recommendations, the PHSO should ensure relevant bodies have been informed about their recommendations and the level of compliance with those recommendations. *The PHSO should include compliance information in its Annual Reports and should set out the steps it has taken to maximise compliance with, and impact of, its reports. As part of this work, the PHSO should strengthen its relationships with Departmental Select Committees, especially at official level. Select Committees would benefit from learning about findings against Departments ahead of sessions with Permanent Secretaries on the annual reports and accounts.* (Paragraph 55)

16. There are obvious advantages to improving complaints handling by frontline bodies. If people are satisfied with the way their complaint has been handled in the first instance, this means they will feel they have had a more efficient resolution to their complaint and they will be less likely to pursue a complaint with the PHSO. *The Committee supports the PHSO's work on the Complaints Standards Framework and will seek an update at the next scrutiny session on how that framework is received and how its effectiveness is being monitored.* (Paragraph 57)

Annex 1: Our approach to scrutiny

1) The table below sets out the areas that the Committee plans to consistently scrutinise the PHSO throughout this Parliament. It also sets out subjects that are of particular interest as a result of this year's scrutiny hearing. We will of course remain flexible to consider emerging matters each year.

Table 6: Areas of scrutiny

Area of scrutiny	Example expected evidence	Areas of particular interest
PHSO casework performance	- Complainant and organisation feedback recorded against the PHSO's Service Charter commitments. - Internal casework assurance scores. - Written evidence from complainants. - the time taken to complete cases.	- the PHSO's commissioning and use of clinical advice. - KPIs 8,11 and 13. - the impact of covid-19 on PHSO case progression.
Staff management and training	- Civil Service staff survey scores. - Improvements in KPIs (such as KPI 11 on explaining decisions and recommendations.)	Staff views on the quality of training they have received.
Value for money	- The Comptroller and Auditor General signed off the PHSO's annual report and accounts with an unqualified opinion. - Evidence of seeking, learning from and contributing to best practice from the international Ombudsman community. Periodic value for money studies.	The upcoming Spending Review.
Impact on other organisations	- Evidence that recommendations have been followed up. - Evidence of effective engagement with organisations like the Care Quality Commission or Select Committees of the House to maximise impact. - Implementation by organisations of the PHSO's upcoming Complaints Standards Framework.	The impact and effectiveness of the PHSO's Complaints Standards Framework. PHSO's relationships and outreach with Select Committees.

Formal minutes

Tuesday 30 June 2020

Members present:

Mr William Wragg, in the Chair

Ronnie Cowan	David Mundell
Rachel Hopkins	Karin Smyth
Mr David Jones	John Stevenson

Draft Report (*Parliamentary and Health Service Ombudsman Scrutiny 2018–19*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 57 read and agreed to.

Annex agreed to.

Summary agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order 134.

[Adjourned till Thursday 2 July 2020 at 08.55am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Monday 18 May 2020

Rob Behrens CBE, Parliamentary and Health Service Ombudsman; **Amanda Amroliwala CBE**, Chief Executive Officer and Deputy Ombudsman	Q1–55

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

HOS numbers are generated by the evidence processing system and so may not be complete.

1 A1 (HOS0003)

2 A2 (HOS0010)

3 A3 (HOS0016)

4 A4 (HOS0023)

5 A5 (HOS0034)

6 Abbott, Mr Michael (HOS0004)

7 Baker, Keith (HOS0038)

8 Banks, Miss Peggy (HOS0035)

9 Banks, Miss Peggy (HOS0005)

10 Brooks, Maggie and Janet (HOS0030)

11 Bunn, Deborah (HOS0029)

12 Cooper, Mr Brian (HOS0021)

13 Czarnetzki, David (HOS0001)

14 Parliamentary and Health Service Ombudsman (HOS0022)

15 Fletcher, Mr Simon (HOS0002)

16 Hart, Nic (HOS0033)

17 Holton, Miss Elisa (HOS0036)

18 Kampalis, A (HOS0026)

19 Kampalis, A (HOS0031)

20 Loescher, Mr and Mrs Jonathan and Elaine (HOS0024)

21 Perloff, Liz (HOS0020)

22 Prentice, Mrs Brenda (HOS0007)

23 Pugh, Mr Paul (HOS0015)

24 Reid, Mr Alan (HOS0014)

25 Reynolds, Mrs Della (HOS0008)

26 Rhodes, Neil (HOS0013)

27 Ridley, Ms Rosamund (HOS0009)

28 Rock, C N (HOS0027)

29 Roditelev, Paul (HOS0012)

30 Simmons, J (HOS0039)

31 Smart, Martin (HOS0032)

32 Steele, Mrs Teresa (HOS0037)

33 Thompson, Mr. Kenneth (HOS0011)

34 Treharne Oakley (HOS0006)

35 Whalley, Margaret (HOS0017)

36 Wheatley, Mr Nicholas (HOS0025)

37 Wickett, Dr Tony (HOS0018)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2019–21

First Report	Appointment of Rt Hon Lord Pickles as Chair of the Advisory Committee on Business Appointments	HC 168
First Special Report	Electoral law: The Urgent Need for Review: Government Response to the Committee's First Report of Session 2019	HC 327