



House of Commons
Public Administration
and Constitutional Affairs
Committee

**Parliamentary and
Health Service
Ombudsman Scrutiny
2019–20**

Seventh 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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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.

The Committee has already set out that it will scrutinise the PHSO under the following categories:

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

The PHSO annual report produces information on the outcomes of all enquiries and complaints in the financial year. The Committee has heard criticism of the quality of this information and the Chief Executive acknowledged that the report has suffered from grouping data in a way that allows historic comparisons. The Committee is pleased that the PHSO is examining how data is presented and hopes to see improvements. The report should include more detail on open cases and time to allocate cases, and comparisons in these areas will be important in future years to help understand the impact of the covid-19 pandemic on the PHSO's work.

The periodic peer review studies commissioned by the PHSO provide an opportunity to compare the PHSO's effectiveness with other ombudsman institutions around the world. The Committee will use these as a source of assurance on, and tool for scrutinising, the PHSO's processes and in turn its value for money. There have been previous calls for modernising legislation to reform the PHSO and improve its effectiveness. This Committee reiterates that this should be prioritised because the PHSO is the final stage in the complaints process for many complainants who need to have complete faith in this organisation at this critical time.

The PHSO has already agreed to publish its casework online in future, to allow regulatory bodies and all interested parties to understand and follow up PHSO recommendations. This in turn will help to demonstrate the PHSO's impact on other organisations.

1 Introduction

The Parliamentary and Health Service Ombudsman

1. The Parliamentary and Health Service Ombudsman (“PHSO” or “Ombudsman”) 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. Mr Behrens is referred to as “the Ombudsman” and the organisation as “the PHSO”. There are separate ombudsman arrangements for local government services in England and for public services provided by the devolved governments, and these are not accountable to this Committee.

2. The Ombudsman is independent of the Government, the NHS and Parliament, but 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. PACAC 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 the Committee (or another select committee) may then scrutinise. An example of such a report was the *Missed opportunities* report.³

3. The Committee held an evidence session on 23 November 2020 with the Ombudsman and Amanda Amroliwala, the Chief Executive Officer and Deputy Ombudsman. This report sets out our conclusions and recommendations following that evidence session. As ever, the Committee is grateful to everyone who submitted evidence as part of the scrutiny session. As part of their submissions, witnesses often recount examples of great personal or familial pain and we are grateful to them for taking the time to share their experiences with us.

Our approach to scrutinising the PHSO

4. As set out in our previous report, our scrutiny of the PHSO broadly follows the following categories:

- casework and productivity;
- staff management;
- value for money; and
- impact on other organisations.⁴

1 Parliamentary and Health Service Ombudsman, “[Who we are](#)” accessed 27 May 2020

2 Standing Orders (Public Business) 5 November 2019

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

4 Public Administration and Constitutional Affairs Committee Second Report of Session 2019–21, [Parliamentary and Health Service Ombudsman Scrutiny 2018–19](#), HC 117, para 5

5. The previous scrutiny hearing was held on 18 May 2020, with a report published on 3 July 2020. This means the most recent scrutiny hearing was held just six months after the last. Therefore, this report is shorter and focused primarily on:

- the PHSO’s casework as measured by the feedback received against its Service Charter commitments;
- the information the PHSO provides in its annual report; and
- the composition of the next value for money study.

6. Furthermore, as our previous report considered the PHSO’s results from the staff survey 2019, this was not considered at this time and the conclusions from our previous report hold.⁵

2 The PHSO's casework

7. This chapter examines:

- the level of demand for the PHSO's services; and
- the performance of the PHSO against its service charter commitments.

The level of demand for PHSO services

8. The PHSO's annual report provides information on the outcomes of all enquiries and complaints in the financial year. The table below provides a comparison of the figures for 2018–19 and 19–20.

Table 1: PHSO productivity

Number of ...	2018–19	2019–20
Enquiries received ⁶	112, 262	103,965
Enquiries with advice provided or redirected	82,998	73,070
Complaints handled (some received last year)	29,841	30,895
Complaints not ready to be or should not be taken forward	24,183	25,659
Decisions made	5,658	5,236
Investigations upheld/partly upheld	746	650
Investigations not upheld	871	472
Assessment decisions ⁷	3,597	3,742
Resolutions ⁸	444	372

Source: Parliamentary and Health Service Annual Report and Accounts [2018–19](#) and [2019–20](#)

9. It should be noted that although the information provided includes a return of “enquiries received” in a particular financial year, the figure does not include information on cases that have not been concluded and also includes enquiries from previous years (particularly, for example, investigations that are still ongoing).

6 This includes all enquiries submitted to the PHSO. This will include complaints but also one-off enquiries such as whether a particular body is within the PHSO's jurisdiction.

7 This means the PHSO assessed the details of a complaint and decided it cannot add benefit by investigating. This could be because the PHSO cannot see that there has been a service failure or the organisation complained about has already put right mistakes made.

8 A resolution is where a complaint closed with a positive outcome for the complainant without the need for an investigation, for example an apology, further explanation or financial remedy provided.

10. The quality of the information provided by the PHSO’s annual report was criticised by one witness to our inquiry, who criticised in particular the fact that the information groups together the categories of “complaints not ready to be taken forwards” and “complaints that should not be taken forward” into a single figure, as well as similarly grouping the “partially upheld” and “fully upheld” categories.⁹ The PHSO used to report separately the numbers for complaints fully upheld and partially upheld.¹⁰

11. In oral evidence, Amanda Amroliwala suggested that the PHSO’s annual report “suffers in some ways from historical comparisons”, as data was grouped in a similar way year-on-year to allow for comparisons. She told us the PHSO was examining the information it provides in its annual report and the presentation of data.¹¹

12. The information provided in the PHSO’s annual report on the outcome of enquiries and complaints should be made more transparent. The grouping of cases that “are not ready to be taken forward” and “should not be taken forward” should be ended. Presumably the former could still lead to investigations being conducted while the latter would not. The PHSO should also separately report on complaints partially and fully upheld.

13. In the previous scrutiny session held in May 2020, Rob Behrens told the Committee that the PHSO had experienced an increase in demand for its services of 13 per cent.¹² However, this is not supported by the annual report and accounts. The annual report and accounts stated that 103,965 enquiries were received, compared to 112,262 in the year before, which represents a decline in enquiries. Dr Bruce Newsome criticised the PHSO’s use of this statistic, asserting it misled Parliament.¹³ When asked about this via correspondence Rob Behrens responded that:

In the first eight months of 2019–20, there was a 13 per cent increase in the number of enquiries we received compared to the same period in 2018–19, using the same method of recording enquiries.

In December 2019, we introduced a new digital casework management system. The new system has many benefits and enables a more robust way of recording information about casework. However, this means that the number of enquiries received in the final four months of 2019–20 is not directly comparable with the same period the year before. This means the total number of recorded enquiries received in 2019–20 overall is lower than in 2018–19, despite the increased enquiries received in the first eight months of 2019–20 ...

The increased enquiries received in the first eight months of 2019–20 translated into an increase in the number of new complaints we received in 2019–20 as a whole, compared to the year before. In 2019–20 we received 31,365 new complaints, which is 7.2 per cent more than the 29,264 in 2018–19.¹⁴

9 A4, (PHS 16)

10 See for example, [Parliamentary and Health Service Ombudsman Annual Report and Accounts 2017–18](#)

11 [Q5](#)

12 [Q47](#), Parliamentary and Health Service Ombudsman Scrutiny 2018–19

13 Dr Bruce Newsome (PHS 02)

14 [Correspondence with the Parliamentary and Health Service Ombudsman](#), dated 12 October 2020

14. In May 2020, the PHSO reported to the Committee that it had experienced an increase of 13 per cent in demand compared to the previous financial year. Due to the introduction of a new digital casework management system, comparisons between years were not possible. This means that the 13 per cent figure cannot be evidenced. The PHSO made no effort to proactively correct the record. If witnesses provide evidence to select committees which is later demonstrated not to be evidence, those witnesses should correct the record. This responsibility is especially applicable for bodies that are scrutinised by those select committees.

PHSO performance against Service Charter Commitments

15. Feedback against the PHSO’s Service Charter provides a useful source of information on the PHSO’s performance. However, due to the PHSO’s new case management system, the number of complainants surveyed in the last two quarters of the financial year was limited, which the PHSO argued affects the reliability of the scores presented.¹⁵ The tables below compare the PHSO’s performance in 2019–20 and 2018–19.

Table 2: Giving you the information you need

Commitment	2019–20 score	2018–19 score
1. We will explain our role and what we can and cannot do	79%	79%
2. We will explain how we handle complaints and what information we need from you	79%	80%
3. We will direct you to someone who can help with your complaint if we are unable to, where possible	72%	78%
4. We will keep you regularly updated on our progress with your complaint	79%	81%
Overall section score against a KPI of 84% ¹⁶	77%	79%

Source: [Parliamentary and Health Service Annual Report and Accounts 2019–20](#)

15 Parliamentary and Health Service Annual Report and Accounts [2019–20](#), pg 41

16 The target score was 75% in 2018–19.

Table 3: Following an open and fair process

Commitment	2019–20 score	2018–19 score
5. We will listen to you to make sure we understand your complaint	72%	73%
6. We will explain the specific concerns we will be looking into	87%	88%
7. We will explain how we will do our work	77%	77%
8. We will gather all the information we need, including from you and the organisation you have complained about, before we make our decision	51%	48%
9. We will share facts with you, and discuss with you what we are seeing	70%	68%
10. We will evaluate the information we have gathered and make an impartial decision on your complaint	-	-
11 We will explain our decision and recommendations, and how we reached them	47%	53%
Overall section score against a KPI of 69% ¹⁷	67%	68%

Source: [Parliamentary and Health Service Annual Report and Accounts 2019–20](#)

Table 4: Giving you a good service

Commitment	2019–20 score	2018–19 score
12. We will treat you with courtesy and respect	89%	90%
13. We will give you a final decision on your complaint as soon as we can	50%	53%
14. We will make sure our service is easily accessible to you and give you support and help if you need it	65%	67%
Overall section score against a KPI of 71% ¹⁸	68%	70%

Source: [Parliamentary and Health Service Annual Report and Accounts 2019–20](#)

16. As a result of successfully meeting its target scores, the PHSO increased its key performance indicators (“KPIs”) with an aim for the targets to be “realistic but stretching.”¹⁹ However, in oral evidence, Amanda Amroliwala admitted it is difficult for the PHSO to improve its scores in this area because the ultimate outcome of complaints plays a serious role in people’s views of the PHSO.²⁰ In its previous report, the Committee raised in particular the scores against service charter commitments 8, 11 and 13.²¹

17. The Committee welcomes the PHSO’s efforts to set stretching target section scores for its Service Charter commitments, but continues to regard the relatively low scores against commitments 8, 11 and 13 as continuing priority areas for improvement and requests an update from the PHSO when data for the mid-year point is available.

17 The target score was 65% in 2018–19

18 The target score was 67% in 2018–19

19 [Correspondence from Rob Behrens, Parliamentary and Health Service Ombudsman](#), 30 October 2020

20 [Q16](#)

21 Public Administration and Constitutional Affairs Committee Second Report of Session 2019–21, [Parliamentary and Health Service Ombudsman Scrutiny 2018–19](#), HC 117, Annex 1

Gathering all the information the PHSO needs

18. One of the service charter commitments that attracts low scores is “We will gather all the information we need, including from you and the organisation you have complained about, before we make our decision”. The Committee has previously concluded that it is essential that complainants are confident that all relevant evidence has been collected if they are to have faith in the PHSO’s ultimate findings.²²

19. The PHSO’s guidance on its use of evidence provides that it will share the evidence that it has considered on request. The Committee asked Rob Behrens why the PHSO does not routinely share all the evidence it has collected. He responded with concerns about complainants feeling overloaded by the information with which they are provided.²³

20. **The Committee appreciates that there is a risk that complainants could be overwhelmed with information if all the evidence the PHSO has collected is shared with them, but it remains the case that complainants need to be assured that all the evidence they have provided has been properly logged. We recommend as an initial step that the PHSO should at a minimum produce a schedule of evidence that they have collected and that this schedule is shared both with complainants and with the organisations being complained about. This would give both parties assurance at least that all the evidence they have provided has been properly logged. This may help improve scores against service charter commitment 8 on gathering all the necessary information.**

Information provided in the PHSO’s annual report

Number of complaints

21. There is also confusion about how many new complaints the PHSO has received in the financial year. The PHSO’s annual report and accounts asserts that in total the PHSO “handled 30,895 complaints compared with 29,841 last year”. This included cases recorded in the previous year and new complaints recorded in 2020 (28,103).²⁴ However, this information explains only how many complaints were handled; it provides no information on how many complaints have actually been received in total in the financial year. Indeed, in his letter of 12 October 2020, Rob Behrens said the PHSO had in fact received 31,365 new complaints in that financial year. Amanda Amroliwala confirmed this was another area that the PHSO was looking at when examining the data provided in the annual report and accounts.²⁵

22. **The PHSO should report in its annual report and accounts the number of new enquiries and complaints that have been received in that financial year. This number is separate from the number of enquiries and complaints that the PHSO has “handled” in that same financial year.**

22 Public Administration and Constitutional Affairs Committee Second Report of Session 2019–21, [Parliamentary and Health Service Ombudsman Scrutiny 2018–19](#), HC 117, paragraph 12.

23 [Q24](#)

24 Parliamentary and Health Service Annual Report and Accounts [2018–19](#) and [2019–20](#)

25 [Q40](#)

The status of complaints over twelve months old

23. Page 12 of the 2019–20 annual report and accounts stated the number of health cases over twelve months old, which rose to 254 in March 2020. David Czarnetzki argued that the Committee should seek a more detailed breakdown of how long these cases had been open (for example, up to 12 months old, up to two years old and so on).²⁶

24. *The PHSO should provide a breakdown of how long health cases that are over one year old have been open for. This information should also be produced next to the general information the PHSO provides on the amount of time it has taken to close cases in that financial year.*

The time for cases to be allocated

25. The PHSO’s previous annual report explained that complaints were allocated to caseworkers in an average of thirty days.²⁷ However, the 2019–20 report did not provide any similar information on how long it took for cases to be allocated to caseworkers, although it did explain that covid-19 had an impact on cases and that by the end of the financial year the queue stood at 1,014 cases.²⁸ Amanda Amroliwala confirmed that the maximum amount of time complainants would have waited for a case to be allocated (before the PHSO paused its casework in response to covid-19) to a caseworker was eight weeks.²⁹ The PHSO’s written evidence set out that the PHSO decided to pause health service complaints in 26 March and restarted them on 1 July.³⁰

26. *The PHSO should report regularly in its annual report the number of cases in the queue for allocation to a caseworker and the average amount of time it took for cases to be allocated to a caseworker. This will be particularly important to understand the impact covid-19 has had on PHSO services.*

Consideration of cases “out of time”

27. Under the Health Service Commissioners Act 1993, the Ombudsman cannot consider health complaints unless the complaint is brought within a year of the date when the complainant “first had notice of the matters alleged in the complaint”. However, the Ombudsman holds a discretion to investigate such cases anyway “if he considers it reasonable to do so.”³¹ A similar provision exists for parliamentary complaints.³²

28. The Committee has received correspondence from would-be complainants whose complaints have not been looked into as a result of being time-barred. One complainant informed us that in their particular case they had not been informed that they could bring their case to the PHSO and by the time they discovered they could pursue such an action, the PHSO did not look at their complaint because it was not made within the time period.

26 David Czarnetzki, (PHS 04)

27 [Parliamentary and Health Service Ombudsman Annual Report and Accounts 2018–19](#), page 11

28 [Parliamentary and Health Service Ombudsman Annual Report and Accounts 2019–20](#), page 27

29 [Q15](#)

30 [Parliamentary and Health Service Ombudsman](#), (PHS 28)

31 s. 9(4), [Health Service Commissioners Act 1993](#)

32 s. 6(3), [Parliamentary Commissioner Act 1967](#)

29. It is necessary for complaints to the PHSO to be time-limited, as there needs to be some level of certainty about when matters that could potentially be complained about can no longer be taken forward. However, the Committee's view is that if an organisation cannot demonstrate that it has informed complainants in good time of their ability to refer a complaint to the PHSO, then this should be a material consideration in whether the Ombudsman decides to use his discretion to investigate the complaint despite being out-of-time under the legislation. The PHSO should report to the Committee annually about the number of cases that have been "timed out" and how often and why the Ombudsman's discretion has been used.

Time taken to respond to correspondence

30. The Committee has received submissions critical of the time the PHSO takes to respond to correspondence. For example, during the previous scrutiny inquiry Dr Tony Wickett provided examples of the PHSO taking between 11 and 26 weeks to respond to correspondence and suggested the PHSO should commit to responding to correspondence in a reasonable amount of time in the Service Charter.³³

31. *The Committee recommends that the PHSO should publish a target for responding to correspondence, and should track its performance against that standard and report to the Committee each year.*

33 [Dr Tony Wickett](#), (HOS 18), Parliamentary and Health Ombudsman Scrutiny 2018–19

3 Value for Money

Peer review

32. One of the main forms of assurance that the Committee will rely on for value for money are periodic peer review studies commissioned by the Parliamentary and Health Service Ombudsman. These studies provide an opportunity to compare effectiveness of the PHSO against other ombudsman institutions around the world.

33. The first such study was chaired by Peter Tyndall, Ombudsman for the Republic of Ireland and included Caroline Mitchell, Lead Ombudsman, Financial Ombudsman Service and Chris Gill, Lecturer, University of Glasgow. It was published in November 2018.³⁴

34. In the previous scrutiny session, Rob Behrens committed to commissioning another such study before his tenure as Ombudsman ended.³⁵ The Committee does not investigate individual cases and these value for money studies offer the potential to provide a strong level of assurance on the effectiveness of the PHSO casework in particular. In the scrutiny hearing, the Committee put the suggestion to the PHSO that there should be an auditor on the panel with experience of auditing complaint handling organisations. Rob Behrens said he would be “relaxed” about having such an additional member, although he insisted it was key to the peer review process that the people undertaking the review understood the issues facing ombudsman services.³⁶

35. The Committee believes that regular peer review studies will be an important source of assurance of the effectiveness of the PHSO’s processes and in turn, its value for money. The Committee recommends that peer review should include specific assurance on the quality of the PHSO’s casework. This should involve analysing a sample of the PHSO’s recent casework and comparison to the PHSO’s service charter commitments.

36. While peer review does require some degree of understanding of ombudsman services, fresh independent perspectives are valuable to avoid groupthink setting in. The Committee recommends that the next peer review should include in its panel an independent member, such as an auditor who has experience of looking at complaints handling organisations.

37. The Committee recommends that the value for money study should adopt the following broad structure in its report: For each area examined, the report should first set out what is expected to see of a modern ombudsman organisation, it should then explain what it did actually find and finally it should analyse how the PHSO’s performance compares against modern expectations.

34 [Value for Money Study: Report of the independent peer review of the Parliamentary and Health Service Ombudsman](#), Peter Tyndall et. al, 12 November 2018.

35 [Q46](#), Parliamentary and Health Service Ombudsman Scrutiny 2018–19

36 [Q44](#)

The need for legislation

38. The ability of the PHSO to obtain value for money in its work is limited by the outdated legislation that governs it. The Committee, like its predecessor, has called for legislation to reform the PHSO. In its previous report, the Committee concluded:

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.³⁷

39. Specific matters that should be considered as part of any reform include:

- own initiative powers for the PHSO;
- the need to unite the PHSO and the Local Government and Social Care Ombudsman;
- complaints standard authority powers; and
- the MP filter (as part of any change to remove the MP filter, the role of Members in assisting complainants must be secured.)³⁸

40. The Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office, Rt Hon Michael Gove MP, confirmed in correspondence that there was no active work to pursue legislation to merge the PHSO and the Local Government and Social Care Ombudsman, citing pressures on the Government and parliamentary timetable.³⁹

41. The Committee reiterates its conclusion that legislative reform of the PHSO is required. The PHSO’s legislation is out of date compared to modern Ombudsman standards. While the Committee appreciates the pressing priorities facing the Government, including covid-19, reform of the PHSO should not be treated as a trifling matter and unworthy of parliamentary time. The PHSO represents the final stage in a complaints process. For many complainants, their complaints refer to matters of grave seriousness, such as the passing of a loved one, and it is essential they can have complete faith that there is an effective organisation at the end of the process. The outdated legislation undermines this important aim.

37 Public Administration and Constitutional Affairs Committee Second Report of Session 2019–21, [Parliamentary and Health Service Ombudsman Scrutiny 2018–19](#), HC 117, para 51

38 Public Administration and Constitutional Affairs Committee Second Report of Session 2019–21, [Parliamentary and Health Service Ombudsman Scrutiny 2018–19](#), HC 117, para 41–50.

39 [Correspondence with the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office](#), 9 September 2020

4 Impact on other organisations

The importance of demonstrating impact

42. The Committee in the previous scrutiny report recommended that the PHSO should include in its annual report and accounts information about organisations' compliance with the PHSO's recommendations. In its response to that report, the PHSO accepted that recommendation.⁴⁰

43. Some of the evidence the Committee received from complainants was critical of the lack of impact that the PHSO's reports had in their cases, suggesting that service improvements were not made as a result of the process.⁴¹ One reason a person may wish to submit a complaint to the PHSO is to seek for services or processes to be improved so that others won't encounter the same experiences. Accordingly, there is a need for the PHSO's recommendations to be seen as impactful.

Publishing casework online

44. The PHSO has previously explained that it is not a regulator and when it comes to longer-term recommendations, such as the implementation of an action plan, it is not within their remit to follow up on the progress for such a plan. Instead, the PHSO provides bodies such as the CQC with copies of their recommendations for follow-up.⁴²

45. Providing regulatory bodies with copies of reports is not the only way to enable effective follow-up. The PHSO's strategy for 2018–21 includes an ambition to publish most of its casework online. The strategy states that:

We will be routinely publishing our casework online along with levels of compliance in implementing our recommendations, enabling complainants and organisations we investigate to have greater confidence in what we do and how our decisions have made an impact.⁴³

The Ombudsman assured the Committee that the PHSO is on track to reach this goal by the end of March 2021.⁴⁴

46. Routinely publishing the PHSO's casework online, including levels of compliance with the PHSO's recommendations will help to demonstrate the impact of the PHSO on other organisations. For recommendations that are of a more long-term nature, such as forming and implementing an action plan, publishing casework online also helps interested parties to understand and follow-up on the recommendations. An example could be users of a particular NHS trust's services.

40 Second Special Report of Session 2019–21, [Parliamentary and Health Service Ombudsman Scrutiny 2018–19: Parliamentary and Health Service Ombudsman's response to the Committee's Second report](#), HC 822

41 See, for example, Mrs Susan Forsey ([PHS 13](#)); and Dr Minh Alexander and Ms Clare Sardari ([PHS 18](#))

42 [Q36](#), Parliamentary and Health Service Ombudsman Scrutiny 2018–19

43 [Our strategy 2018–21, Delivering an exemplary ombudsman service](#), Parliamentary and Health Service Ombudsman, pg 15

44 [Q47](#)

Conclusions and recommendations

The PHSO's casework

1. The information provided in the PHSO's annual report on the outcome of enquiries and complaints should be made more transparent. The grouping of cases that "are not ready to be taken forward" and "should not be taken forward" should be ended. Presumably the former could still lead to investigations being conducted while the latter would not. The PHSO should also separately report on complaints partially and fully upheld. (Paragraph 12)
2. In May 2020, the PHSO reported to the Committee that it had experienced an increase of 13 per cent in demand compared to the previous financial year. Due to the introduction of a new digital casework management system, comparisons between years were not possible. This means that the 13 per cent figure cannot be evidenced. The PHSO made no effort to proactively correct the record. If witnesses provide evidence to select committees which is later demonstrated not to be evidence, those witnesses should correct the record. This responsibility is especially applicable for bodies that are scrutinised by those select committees. (Paragraph 14)
3. The Committee welcomes the PHSO's efforts to set stretching target section scores for its Service Charter commitments, but continues to regard the relatively low scores against commitments 8, 11 and 13 as continuing priority areas for improvement and requests an update from the PHSO when data for the mid-year point is available. (Paragraph 17)
4. The Committee appreciates that there is a risk that complainants could be overwhelmed with information if all the evidence the PHSO has collected is shared with them, but it remains the case that complainants need to be assured that all the evidence they have provided has been properly logged. *We recommend as an initial step that the PHSO should at a minimum produce a schedule of evidence that they have collected and that this schedule is shared both with complainants and with the organisations being complained about. This would give both parties assurance at least that all the evidence they have provided has been properly logged. This may help improve scores against service charter commitment 8 on gathering all the necessary information.* (Paragraph 20)
5. *The PHSO should report in its annual report and accounts the number of new enquiries and complaints that have been received in that financial year. This number is separate from the number of enquiries and complaints that the PHSO has "handled" in that same financial year.* (Paragraph 22)
6. *The PHSO should provide a breakdown of how long health cases that are over one year old have been open for. This information should also be produced next to the general information the PHSO provides on the amount of time it has taken to close cases in that financial year.* (Paragraph 24)

7. *The PHSO should report regularly in its annual report the number of cases in the queue for allocation to a caseworker and the average amount of time it took for cases to be allocated to a caseworker. This will be particularly important to understand the impact covid-19 has had on PHSO services. (Paragraph 26)*
8. It is necessary for complaints to the PHSO to be time-limited, as there needs to be some level of certainty about when matters that could potentially be complained about can no longer be taken forward. However, the Committee's view is that if an organisation cannot demonstrate that it has informed complainants in good time of their ability to refer a complaint to the PHSO, then this should be a material consideration in whether the Ombudsman decides to use his discretion to investigate the complaint despite being out-of-time under the legislation. The PHSO should report to the Committee annually about the number of cases that have been "timed out" and how often and why the Ombudsman's discretion has been used. (Paragraph 29)
9. *The Committee recommends that the PHSO should publish a target for responding to correspondence, and should track its performance against that standard and report to the Committee each year. (Paragraph 31)*

Value for Money

10. The Committee believes that regular peer review studies will be an important source of assurance of the effectiveness of the PHSO's processes and in turn, its value for money. *The Committee recommends that peer review should include specific assurance on the quality of the PHSO's casework. This should involve analysing a sample of the PHSO's recent casework and comparison to the PHSO's service charter commitments. (Paragraph 35)*
11. *While peer review does require some degree of understanding of ombudsman services, fresh independent perspectives are valuable to avoid groupthink setting in. The Committee recommends that the next peer review should include in its panel an independent member, such as an auditor who has experience of looking at complaints handling organisations. (Paragraph 36)*
12. *The Committee recommends that the value for money study should adopt the following broad structure in its report: For each area examined, the report should first set out what is expected to see of a modern ombudsman organisation, it should then explain what it did actually find and finally it should analyse how the PHSO's performance compares against modern expectations. (Paragraph 37)*
13. *The Committee reiterates its conclusion that legislative reform of the PHSO is required. The PHSO's legislation is out of date compared to modern Ombudsman standards. While the Committee appreciates the pressing priorities facing the Government, including covid-19, reform of the PHSO should not be treated as a trifling matter and unworthy of parliamentary time. The PHSO represents the final stage in a complaints process. For many complainants, their complaints refer to matters of grave seriousness, such as the passing of a loved one, and it is essential they can have complete faith that there is an effective organisation at the end of the process. The outdated legislation undermines this important aim. (Paragraph 41)*

Impact on other organisations

14. Routinely publishing the PHSO's casework online, including levels of compliance with the PHSO's recommendations will help to demonstrate the impact of the PHSO on other organisations. For recommendations that are of a more long-term nature, such as forming and implementing an action plan, publishing casework online also helps interested parties to understand and follow-up on the recommendations. An example could be users of a particular NHS trust's services. (Paragraph 46)

Annex 1: Priorities for scrutiny

As in our previous report, this annex sets out priorities for our scrutiny of the PHSO.

Table 5: Areas of scrutiny

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

Formal minutes

Tuesday 19 January 2021

Members Present

Mr William Wragg, in the Chair

Ronnie Cowan	Tom Randall
Jackie Doyle-Price	Lloyd Russell-Moyle
Rachel Hopkins	Karin Smyth
Mr David Jones	John Stevenson

Draft Report (*Parliamentary and Health Service Ombudsman Scrutiny 2019–20*) proposed by the Chair, brought up and read.

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

Paragraphs 1 to 46 agreed to.

Annex and Summary agreed to.

Resolved, That the Report be the Seventh 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 Tuesday 26 January 2021 at 9.30am

Witnesses

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

Monday 23 November 2020

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

[Q1–53](#)

Published written evidence

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

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

- 1 A1 ([PHS0001](#))
- 2 A3 ([PHS0015](#))
- 3 A4 ([PHS0016](#))
- 4 A6 ([PHS0020](#))
- 5 A7 ([PHS0023](#))
- 6 Alexander, Dr Minh; and Ms Clare Sardari ([PHS0018](#))
- 7 Banks, Miss Peggy ([PHS0006](#))
- 8 Burton, Mr Nick ([PHS0021](#))
- 9 Cooper, Mr Brian ([PHS0022](#))
- 10 Czarnetzki, David ([PHS0004](#))
- 11 Drew, Dr David (Retired, NHS) ([PHS0008](#))
- 12 Forsey, Mrs Susan ([PHS0013](#))
- 13 Green, John L ([PHS0017](#))
- 14 Holton, Elisa ([PHS0030](#))
- 15 Latif, Mr Shire ([PHS0014](#))
- 16 Martin, Ms Frances ([PHS0005](#))
- 17 Mullen, Christine ([PHS0024](#))
- 18 Newsome, Dr. Bruce (Lecturer, University of San Diego) ([PHS0002](#))
- 19 Perloff, Liz ([PHS0031](#))
- 20 Prentice, Mrs Brenda (now retired , Home) ([PHS0009](#))
- 21 Ridley, Rosamund ([PHS0011](#))
- 22 Rock, Colin N ([PHS0027](#))
- 23 Service, Parliamentary and Health ([PHS0028](#))
- 24 Steele, Mrs Teresa ([PHS0012](#))
- 25 Watts, Fiona ([PHS0032](#))
- 26 Whalley, Mrs Margaret ([PHS0007](#))
- 27 Wheatley, Nicholas ([PHS0026](#))
- 28 Wheatley, Nicholas ([PHS0025](#))
- 29 phsothefacts ([PHS0010](#))

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](#).

Session 2019–21

Number	Title	Reference
1st	Appointment of Rt Hon Lord Pickles as Chair of the Advisory Committee on Business Appointments	HC 168
2nd	Parliamentary and Health Service Ombudsman Scrutiny 2018–19	HC 117
3rd	Delivering the Government's infrastructure commitments through major projects	HC 125
4th	Parliamentary Scrutiny of the Government's handling of Covid-19	HC 377
5th	A Public Inquiry into the Government's response to the Covid-19 pandemic	HC 541
6th	The Fixed-term Parliaments Act 2011	HC 167
1st Special	Electoral law: The Urgent Need for Review: Government Response to the Committee's First Report of Session 2019	HC 327
2nd Special	Parliamentary and Health Service Ombudsman Scrutiny 2018–19: Parliamentary and Health Service Ombudsman's response to the Committee's Second report	HC 822
3rd Special	Delivering the Government's infrastructure commitments through major projects: Government Response to the Committee's Third report	HC 853
4th Special	A Public Inquiry into the Government's response to the Covid-19 pandemic: Government's response to the Committee's Fifth report	HC 995
5th Special	Parliamentary Scrutiny of the Government's handling of Covid-19: Government Response to the Committee's Fourth Report of Session 2019–21	HC 1078
6th Special	The Fixed-term Parliaments Act 2011: Government's response to the Committee's Sixth report of Session 2019–21	HC 1082