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Public Administration and Constitutional Affairs Committee
Parliamentary and Health Service Ombudsman Scrutiny 2021-22

Summary

1. Casework Performance.
2. PHSO Annual Report 2021-2022.
3. Impact on Other Organisations.
4. Value for Money.

1. Casework Performance

a) 90% reduction in the number of Parliamentary investigations carried out by the PHSO

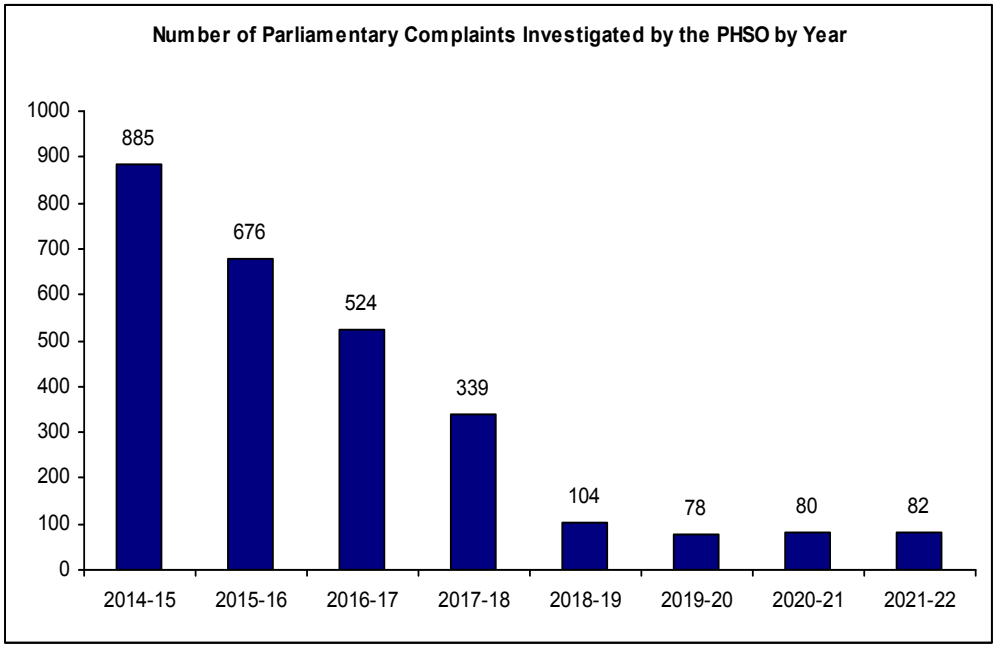
The graphs below show that there has been a 90% reduction in the total number of Parliamentary investigations carried out by the PHSO since 2014-15.

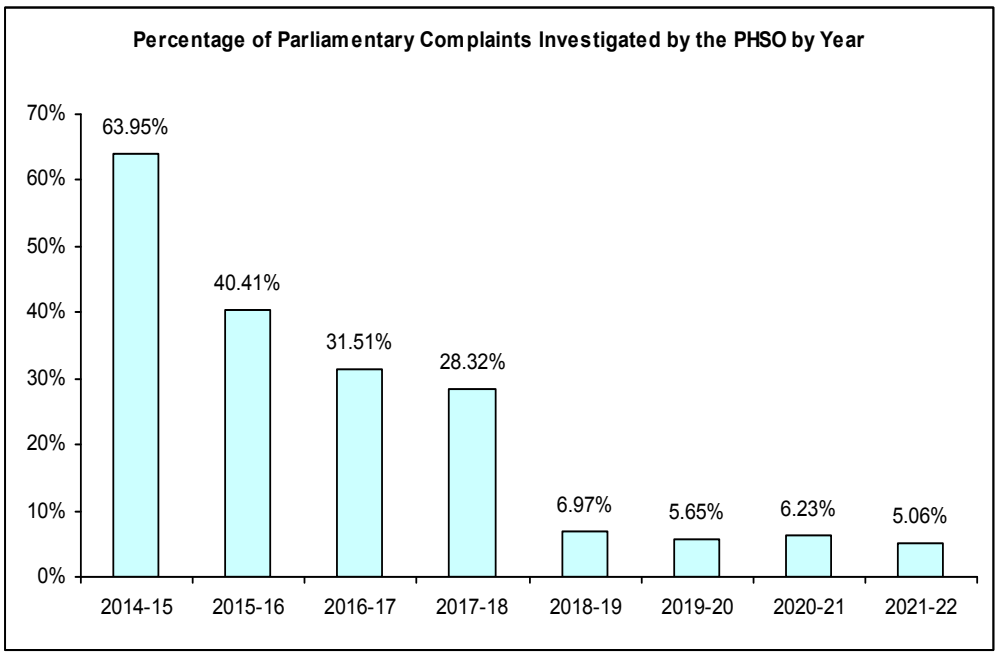
In 2014-15 about 64% of Parliamentary complaints were investigated, while in 2021-22 only about 5% were investigated.

Committee members will be well aware that the complaints they submit to the PHSO on behalf of their constituents are rarely investigated these days.

The data for the graphs comes from PHSO documents found in the corporate publications section of the PHSO website.

https://www.ombudsman.org.uk/publications/complaints-parliamentary-and-health-service-ombudsman-2021-22





b) 85% reduction in all investigations carried out by the PHSO

When the report on the Parliamentary and Health Service Ombudsman Scrutiny 2020-21 was read out in the Committee Meeting of 17th May 2022, it incorrectly stated in paragraph 9 that the number of investigations was on a downward trend from 2,348 in 2017-18 to 1,494 in 2019-20, which would represent a decrease of 36% in 2 years.

The report was later corrected to show that there were in fact just 1,122 investigations in 2019-20, which represents a decrease of 52% over 2 years.

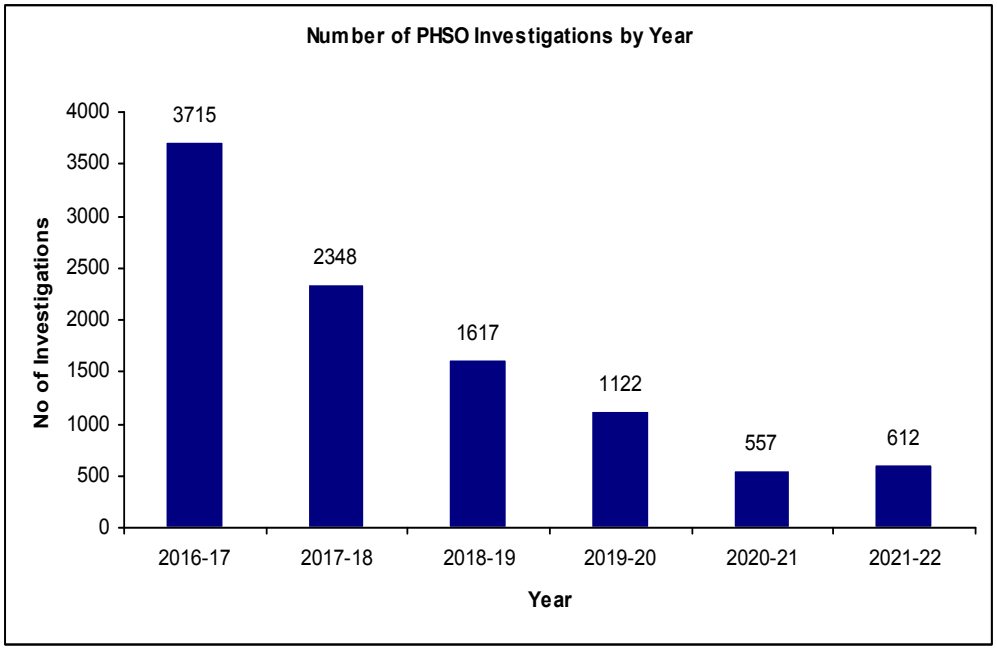
As can be seen from the graphs below the number of investigations has actually decreased from 3,715 in 2016-17 to 612 in 2021-22. A decrease of 85%.

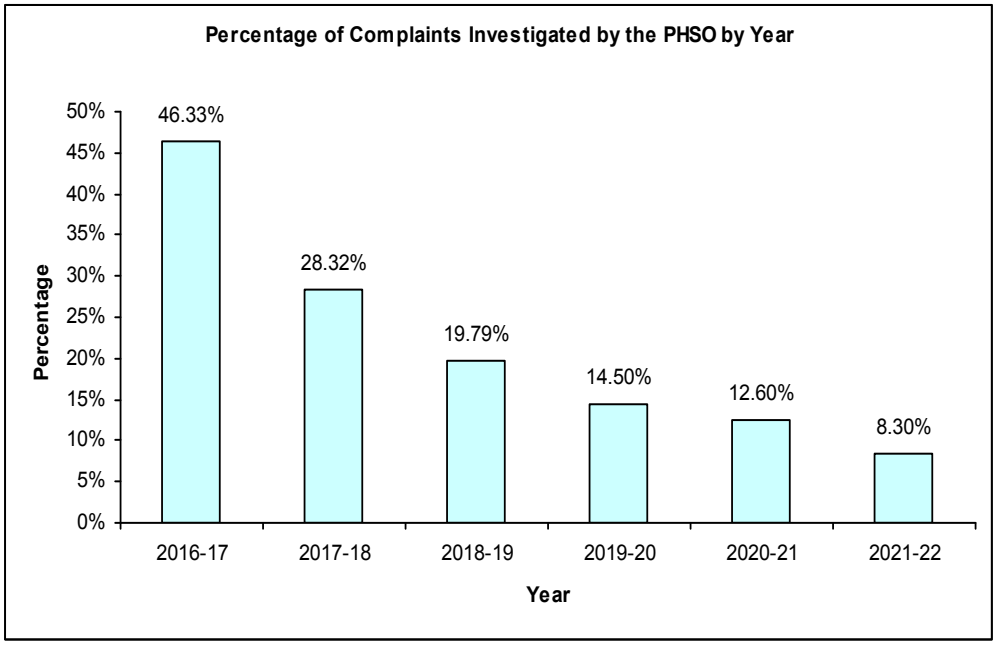
In 2016-17 about 46% of all complaints made to the PHSO were investigated. In 2021-22 only about 8% of all complaints were investigated.

The data for the graphs comes from the PHSO Annual Accounts found in the corporate publications section of the PHSO website.

The decrease in the percentage of complaints investigated in 2021-22 despite the small increase in the number of complaints investigated is as a result of the 24% increase in complaints coming to the PHSO in that year.

Because there is a lag between a complaint being accepted and a decision being made the figure for the percentage of complaints investigated is an approximation.





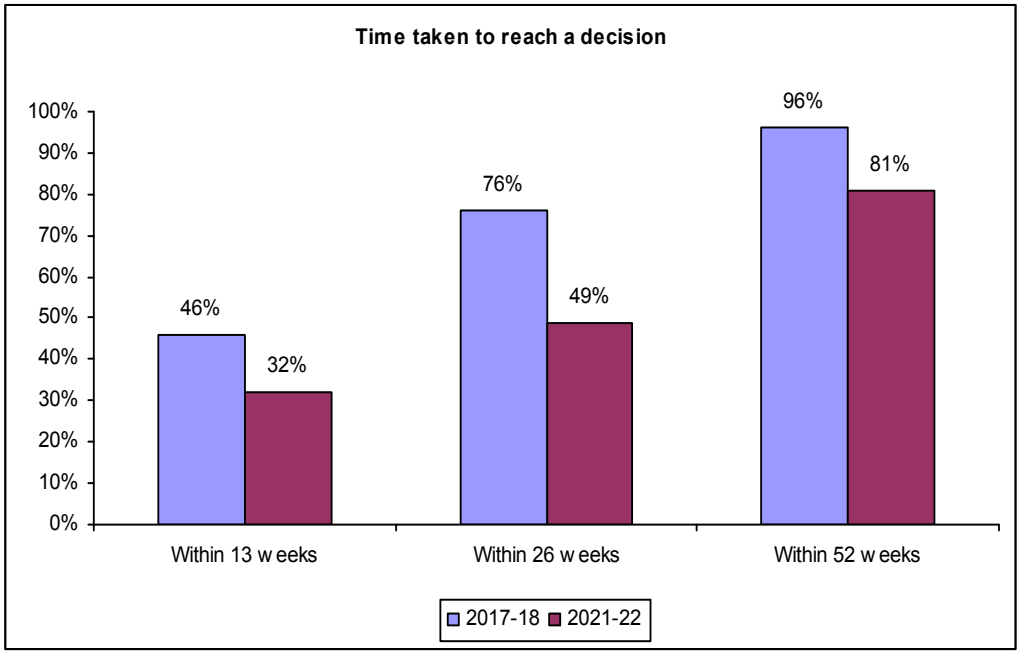
2. PHSO Annual Report 2021-2022

a) 110% increase in complaints concluded for "Other reason…"

The table on page 31 of the annual report shows a large increase in the number of investigations concluded for "Other reason…". In 2021-22 there were 3,123 complaints concluded for this reason compared with an average of 1,484 over the previous 3 years. That represents a 110% increase. No reason is given in the report for this large increase.

b) Large increases in the time taken to reach a decision

The graph below shows large increases in the time taken to reach a decision on complaints which undergo further consideration, when comparing 2017-18 data found on page 36 of the 2019-20 annual report with 2021-22 data found on page 32 of the 2021-22 annual report.



c) No differentiation between primary investigations and detailed investigations in the Time Taken to Reach a Decision table.

Fewer than 10% of complaints which underwent further consideration in 2021-22 went on to the detailed investigation stage.

However 19% of complaints which underwent further consideration took longer than 52 weeks to conclude.

Since detailed investigations take much longer to conclude than primary investigations this strongly suggest that in 2020-21 detailed investigations took more than one year on average to conclude.

Without any differentiation between primary and detailed investigations in the Time Taken to Reach a Decision table on page 32 of the annual report it is not possible to tell exactly how long it took to conclude detailed investigations in 2021-22.

d) Recommendations and Compliance

The table on page 33 of the annual report shows that the PHSO made 294 recommendations for service improvements in 2021-22.

It would be very useful for public confidence, value for money considerations, and no doubt helpful for the Committee as well, if the PHSO were to publish details of all the recommendations for service improvements made in any year.

e) No differentiation between positive feedback from organisations and positive feedback from complainants

On page 36 of the annual report it states that the PHSO received 86 pieces of positive written feedback "from people who use our service and from organisations we investigate".

The amount of positive feedback is not differentiated between complainants and organisations.

In paragraph 31 of the Parliamentary and Health Service Ombudsman Scrutiny Report 2020-21 it states that:

"This is important for the Committee because we receive a significant amount of correspondence from the public, much of it negative in its nature due to complainants having their cases rejected and seeking redress."

In fact the vast majority of feedback from complainants to the PHSO is negative. This is not just *"due to complainants having their cases rejected"* but also due to the unjust and biased nature of investigations conducted by the PHSO.

Paragraph 31 of the Parliamentary and Health Service Ombudsman Scrutiny Report 2020-21 goes on to state that:

"It is likely that any feedback giving praise or alternative positive views are sent directly to the PHSO, or posted in different form, rather than being provided directly to the Committee"

However a Freedom of Information request shows that, in 2016-17, feedback to the PHSO included just 8 compliments.

https://www.whatdotheyknow.com/request/happiness_of_complainants_with_p

It would be useful for clarity and transparency if the PHSO would publish figures for the amount of positive and negative feedback, both from complainants and also from organisations.

f) Customer Satisfaction

In paragraph 31 of the Parliamentary and Health Service Ombudsman Scrutiny Report 2020-21, it states that according to Ms. Amroliwala

"We conducted a survey in 2018–19 on exactly this point and asked people who had had their cases upheld if they were satisfied or not with the quality of the service. Of those who had had their cases upheld, 86% said yes, they were very happy with the quality. Only 47% of those who did not have their case upheld said that they were happy with the quality, so you can see the scale of difference."

A Freedom of Information request has now confirmed that the satisfaction figures quoted do not relate to the overall quality of the service but only to satisfaction with the customer service (replying to phone calls, responding to emails etc.).

https://www.whatdotheyknow.com/request/869584/response/2062964/attach/3/Matrix%20of%20complainant%20survey%20questions.pdf?cookie_passthrough=1

Customer satisfaction with the overall service is likely a lot lower than portrayed in the statistics quoted by Ms Amroliwala. A complainant feedback survey was produced by the PHSO in 2015-16 with detailed statistics.

https://www.ombudsman.org.uk/sites/default/files/Complainant_feedback_survey_2015-16.pdf

It lists the following statistics for complaints that were not upheld:

15% satisfied that the decision was fair and unbiased
14% satisfied that the outcome followed a thorough assessment
14% satisfied that evidence was produced to support the decision.

It is likely that if the 2021-22 Service Charter results were differentiated by decision then similar results to those shown above would be obtained.

3. Impact on other Organisations

The PHSO has produced a number of reports over the years but they seem to have had remarkably little impact on the organisations reported on. There is also very little feedback or follow up on the reports and when there is it is usually not very positive.

DWP

In the foreword to the annual report the Ombudsman mentions a report produced by the PHSO in January 2022 relating to compensation payments to people who had been underpaid in regards to their ESA benefits. It should be made clear that it was the DWP who identified the error and refunded the lost money. The PHSO complaint related to compensation payments.

https://www.ombudsman.org.uk/sites/default/files/HC956_An_investigation_into_the_Department_for_Work_and_Pensions....pdf

However, according to an article by the journalist David Hencke, the DWP has ignored the recommendations for compensation made by the PHSO. He states:

"The decision also shows up the weakness of complaining about maladministration to the Parliamentary Ombudsman, Robert Behrens, in cases involving the ministry as it ignores his rulings"

https://davidhencke.com/2022/08/07/dwp-ignores-the-parliamentary-ombudsman-and-refuses-to-compensate-118000-disabled-people-hit-by-benefit-maladministration/

Maternity Care

There have been multiple failures of maternity care identified by independent reports, most recently the report into the failures at East Kent.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1111992/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf

Yet despite hundreds of cases of failure now being identified, the PHSO has been remarkable by its absence. It might be thought that a complaints organisation should have picked up the problems with maternity care. Yet it seems that no-one complained to the PHSO.

The PHSO did produce a report in 2013 into failures of maternity care at Furness General Hospital but it seems to have had little effect on the standards of care across the NHS.

https://www.ombudsman.org.uk/sites/default/files/Midwifery_supervision_and_regulation_Mr_M_report.pdf

Mental Health Services

In 2019 the Ombudsman produced a report into failings in the care and treatment of two young men with mental health problems at North Essex Partnership University NHS Foundation Trust.

https://www.ombudsman.org.uk/sites/default/files/page/Missed_opportunities_What_lessons_can_be_learned_from_failings_at_the_North_Essex_Partnership_University_NHS_Foundation_1.pdf

In October 2022 Channel 4 Dispatches showed a documentary about the same North Essex Partnership University NHS Foundation Trust which in their words stated that "…an NHS Trust responsible for serious failures resulting in multiple deaths still isn't keeping patients safe".

https://www.channel4.com/programmes/hospital-undercover-are-they-safe-dispatches/on-demand/72849-001

HS2

In 2015 the PHSO produced a report into a complaint against HS2 and it was followed up with a report by PACAC.

https://www.ombudsman.org.uk/publications/report-results-investigation-complaint-about-high-speed-2-ltd-hs2-ltd

https://publications.parliament.uk/pa/cm201516/cmselect/cmpubadm/793/793.pdf

However, 6 years later the very same complainant had to raise another complaint on a similar matter and another report was produced by the Ombudsman. It seems that HS2 had learnt nothing from the first report.

https://www.ombudsman.org.uk/publications/investigation-hs2-ltds-failure-communicate-family-about-acquiring-their-home

Eating Disorders

The Ombudsman published a report into eating disorders after failures of care led to death of a young patient named Averil Hart.

https://www.ombudsman.org.uk/publications/ignoring-alarms-how-nhs-eating-disorder-services-are-failing-patients

On 14 May 2019, 18 months after the Ombudsman published his report, PACAC held a follow up inquiry at which Dr. Dasha Nicholls, Chair of the Faculty of Eating Disorders at the Royal College of Psychiatrists, and Andrew Radford, Chief Executive of BEAT Eating Disorders, gave evidence.

When asked what impact the report had made, Dr Nicholls replied “As yet I would say relatively little”.

Dr Radford claimed that the situation was “as bad now, if not worse than it was in 2012 when Averil died”.

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-administration-and-constitutional-affairs-committee/phso-report-ignoring-the-alarms-how-nhs-eating-disorders-services-are-failing-patients/oral/102194.pdf

DWP

In the Ombudsman’s Casework Report of 2019, a case concerning the DWP and the new state pension can be found on pages 14 and 15.

https://www.ombudsman.org.uk/sites/default/files/Ombudsman_Casework_Report_2019.pdf

The DWP did not however properly implement the changes recommended in the report.

According to the journalist David Hencke:

"So what happened? Sweet nothing. The DWP ignored the deadline and then produced a factsheet which I know from correspondence the Ombudsman clearly felt did not fit the bill. But after one attempt to get this changed the Ombudsman dumped the issue and wimped out of getting the ministry to implement their recommendations."

https://davidhencke.com/2021/09/12/whitehalls-rip-off-ministry-the-dwp-dodges-paying-compensation-to-millions-of-pensioners-and-the-parliamentary-ombudsman-lets-it-off/

4. Value for Money

a) Does the PHSO provide Value for Money?

It can be seen from the sections above that the PHSO seems to provide very little value for money. The reports it produces seem to be ignored by the organisations reported on, or else they have little effect overall on the provision of services to the public and any learning is not widely disseminated if disseminated at all.

Regarding individual complaints, the PHSO seems to investigate remarkably few, around 10% according to the most recent statistics.

The PHSO did make 294 recommendations for service improvements as a result of investigations into individual complaints, the majority of which were complied with by the relevant organisation. It seems doubtful though that this justifies the budget of the PHSO.

It is also important to take into account the negative impact of the PHSO on people who bring their complaints to the organisation, many of whom state that their experience with the PHSO is more traumatic than the event about which they are complaining.

b) Peer Review

It seems unlikely that a peer review by the International Ombudsman Institute will be able to provide an objective and unbiased assessment of value for money. There is an obvious conflict of interest.

It is also not certain that anyone from the IOI will have the necessary experience of Value for Money analysis to conduct such an assessment.

For example the last peer review study produced in 2018 made much of the value of advice and signposting provided by the PHSO. While this undoubtedly has value it only makes up a very small percentage of the overall budget of the PHSO and so has little relevance to the overall value for money.

A proper VFM analysis might want to look at the number of investigations carried out and the proportion of the budget devoted to these investigations and a consideration of whether the dramatic decline in the number of investigations carried out represents a decline in value for money. It might also want to analyse how much of the budget is spent on work other than investigations.

Only an independent expert in VFM analysis could produce an independent and competent analysis of such issues.

November 2022