PACAC Annual Scrutiny Report 2019-20: response from the Parliamentary and Health Service Ombudsman

25 March 2021

We welcome the Public Administration and Constitutional Affairs Committee's scrutiny of PHSO's performance in 2019-20. We have set out PHSO's response to each of the Committee's recommendations below.

In this response we have numbered each of the Committee's recommendations in line with the numbers used for each recommendation as set out in the Committee's scrutiny report. In places we have grouped related recommendations together, which means that the numbering is not sequential.

Annual Report recommendations

1. The information provided in the PHSO annual report on the outcomes 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. The PHSO should also separately report on complaints partially and fully upheld.

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.

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.

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.

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.

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The Committee has a crucial role in holding PHSO's independent service to account. As an Officer of the House, the Ombudsman is fully committed to being open and transparent about the performance of the service PHSO provides to the public. We are determined, therefore, to give open and accurate accounts of PHSO's performance to the Committee through the annual scrutiny inquiries it holds, in PHSO's Annual Report, and through regular correspondence and dialogue with the Chair.

The Committee's scrutiny report makes a number of detailed recommendations in relation to the presentation of performance data in PHSO's Annual Report. During the oral evidence hearing, we committed to simplify and streamline the Annual Report to make PHSO's performance data more transparent and easier to understand for people using our service. As we advised in the hearing, we had already begun to consider changes to the 2020-21 Annual Report.

In reviewing the way PHSO presents information in future, we will carefully consider the recommendations the Committee has made in its report. In going through the detailed process of preparing the Annual Report, there may be some recommendations that we deliver differently if we identify an alternative approach that would better meet the goal of simplifying and streamlining how data is presented. We will write to the Committee alongside publication of the next Annual Report this summer to explain the final approach we have adopted and invite members to consider whether it delivers the transparency and ease of understanding that the Committee is seeking.

Simplifying and streamlining the Annual Report is also the first step of a much larger programme of work which will change fundamentally how PHSO collects and reports data. This will enable even greater clarity going forward.

As highlighted in the Ombudsman's letters to the Committee Chair on 23 March, 6 April and 12 June 2020, and 28 January 2021, the COVID-19 pandemic has had – and continues to have – a significant impact on PHSO, the people who use our service, and the organisations in PHSO's jurisdiction. Direct comparisons of performance between the data presented in PHSO's 2020-21 Annual Report and data from previous years' Annual Reports will therefore not always be possible. However, we will use the next Annual Report and the report for 2021-22 to reframe how we present data to make our performance as clear as possible for the Committee and the public.

Other recommendations

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.

PHSO is open and transparent about the performance of the service we provide. The information we provided to the Committee in May 2020 was and is correct. Accordingly, the Ombudsman wrote to the Committee on 25 January 2021 to highlight the concerns we had about the drafting of paragraphs 13 and 14 of the Committee's scrutiny report, which implied that we had not been transparent when reporting about enquiries to PHSO during 2019-20.

The Ombudsman first wrote to the Committee Chair about this issue on 30 October 2020. In this letter, and during the oral evidence hearing on 23 November 2020, it was made clear that this was not data from a full financial year. It was instead a comparison between the number of enquiries to PHSO in the first eight months of 2019-20 (prior to the installation of a new IT system) and the number of enquiries to PHSO during the same eight-month period the year before, when a like-for-like comparison could be made. Consequently, there was no reason to correct the record as the information provided remains accurate.

The Committee Chair wrote to the Ombudsman on 26 January 2021 to confirm that "the Committee was not of the opinion that you [the Ombudsman] had misled Parliament, and was clear not to make that accusation in the report".

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.

The Service Charter provides a valuable source of feedback about people's experience of PHSO's service. PHSO is the only public service Ombudsman to regularly carry out and publish a survey of this kind.

PHSO is committed to improving the quality of the service we provide. As we advised the Committee in PHSO's memorandum of 30 October, changes to PHSO's service do not always lead directly to changes in Service Charter feedback, as a number of different factors influence complainants' feedback, including whether PHSO reaches the decisions that the complainant was hoping for. However, we are undertaking a programme of work to continuously improve the quality of PHSO's casework, as we committed to do in PHSO's 2018-21 strategy and we will update the Committee at the next scrutiny inquiry about how we hope these will contribute to improving the experience of complainants in these

important Service Charter areas. Service Charter response data is published quarterly on the PHSO website.

4. 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.

PHSO recognises the importance of being transparent about the material evidence (the evidence which we have taken into consideration in making a decision on a complaint). We set out in each final investigation decision report how material evidence has supported the final decision on each case we have investigated. This evidence is available in full on request. Some evidence gathered will be material evidence that is relevant to PHSO's consideration of a case, but some evidence may not be material to the decision. We consider scheduling non-material evidence would be disproportionate.

We acknowledge that producing and sharing a schedule of the material evidence for investigations could help strengthen complainants' and organisations' understanding of how evidence is used in casework. We already produce a full schedule of material evidence on request in line with our service policy and we believe doing so is a proportionate means of meeting this need.

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.

The Health Service Commissioner Act and Parliamentary Commissioner Act both set a legal time limit of 12 months from the date an individual became aware of a failing for the Ombudsman to investigate. They also give the Ombudsman the power to use their discretion to look at complaints outside of this time limit, if the Ombudsman considers it reasonable to do so when taking into account the specific circumstances of each complaint.

To support this, PHSO's service policy provides guidance for caseworkers on how to approach the time limit and how to use discretion, as set out in PHSO's letter to the Committee Chair on 30 October 2020.

It is good practice that organisations signpost complainants to us. PHSO's letter of 30 October 2020 outlined to the Committee how we work with organisations in PHSO's jurisdiction and referring MPs to raise awareness of PHSO's service.

PHSO is able to look at complaints that have exceeded the 12 months time limit where it considers that it is reasonable to do so. This could include cases where there are special circumstances outside of the complainant's control, for example where an organisation has taken longer than 12 months to complete the local resolution process and the complainant did not then delay bringing their complaint to PHSO.

The Committee recommends that if a body did not notify a complainant of their ability to refer a complaint to PHSO, then this should be a material consideration where a complainant comes to us after 12 months. We agree. This would be an element in PHSO's consideration to explore, along with any other factors, whether discretion should be applied to look at an out of time case.

We collect data on the number of cases we have not looked at due to the time limit, but do not collect data in instances where we have set aside the time limit, as these cases are considered in line with our standard investigation processes. During 2019-20 we recorded 969 cases as out-of-time.

We will shortly be publishing a new version of PHSO's service model policy, which sets out in detail the process that caseworkers follow when looking into a complaint. This will include updated information on how we handle cases that exceed the time limit. This will be available on PHSO's website to support members of the public, complainants, MPs and organisations to understand what cases PHSO can look into.

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.

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.

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 expects 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.

We welcome the Committee's recognition of the benefits of the independent peer review of PHSO's value for money in 2018 and the plans to commission another peer review during the period covered by PHSO's new corporate strategy.

PHSO has been sharing its experience of peer review to encourage other Ombuds services to do the same. The Ombudsman has spoken to the Forum of Canadian Ombudsman on this subject. Further, PHSO has led the development of International Ombudsman Institute guidance to support peer reviews. This now includes the creation of a list of validated

independent panel members which Ombuds can commission when undertaking peer reviews. The list will include academics who have expertise in Ombudsman services and auditors who have experience of Ombudsman services. We recognise the potential value that a panel member with a background in audit may bring, where this is complemented by the the wider range of skills and expertise required to carry out an effective peer review.

In each peer review, the process is led by an independent chair who appoints additional independent members to form a peer review panel. The scope and content of the peer review is negotiated between the commissioning Ombudsman scheme and the independent panel. When PHSO commissions the next peer review (and there may be a delay for logistical reasons associated with travel restrictions during the COVID-19 pandemic), we will notify the peer review chair, once appointed, of the Committee's recommendations regarding the composition of the panel, the scope of the review, and the structure of the panel's final report so that this can be taken into account. It is important to note, however, that the role of a modern national Ombudsman organisation has already been set out by the Venice Principles, now endorsed by the United Nations General Assembly.[1] Further, the value of a peer review lies in its flexibility to examine a range of emerging issues, and that it should be seen as complementary to a range of other audit and assessment mechanisms (Parliamentary scrutiny, internal audit, and audit by the National Audit Office), and not the single source of scrutiny. The way the peer review panel's report is structured will ultimately be decided by the panel's independent chair.

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.

We fully endorse the Committee's recommendation that parliamentary time should be made available to bring forward new legislation to reform PHSO. This view is supported by the Chair of the Liaison Committee who has recently written to the Leader of the House of Commons to seek clarification on Government intentions and plans to conduct pre-legislative scrutiny of the new draft legislation.[2] We welcome the Committee's ongoing engagement with the Cabinet Office to support the case for Ombudsman reform. We note that, so far, there has been no tangible progress.

In the absence of much-needed fundamental Ombudsman reform, PHSO will continue to seek incremental changes to improve the Ombudsman service for people in England and at the UK level. The NHS Integration and Innovation White Paper, for instance, presents an opportunity to modernise PHSO's powers in relation to the NHS so that citizens in England can have the same expectations of good quality complaint handling as those in the devolved nations.

[1] The Venice Principles on the Protection and Promotion of the Ombudsman Institution
[2] Letter from the Chair of the Liaison Committee to the Leader of the House, 17 February 2021

Granting PHSO the powers of a 'Complaints Standards Authority' (CSA), for example, would build on the extensive work PHSO has done in collaboration with the NHS, Government, arms-length bodies, and advocacy groups to establish a single, shared set of Complaints Standards for the NHS. The first iteration of these Standards will be published to facititate pilot projects at the end of March 2021. CSA powers would add greater authority to the Complaints Standards and allow PHSO to take action where public services are not meeting those standards, in line with what PHSO's counterparts can already do in the devolved nations.

The forthcoming NHS legislation could also grant PHSO 'own initiative' powers to look at an NHS-related issue where someone would struggle to bring a complaint or where there is a fear that complaining to the Ombudsman might bring about personal repercussions in terms of the NHS care received. For example, if someone is a long-term inpatient with learning disabilities, they or their family may be reluctant to complain formally for fear that it would adversely affect that person's care.

PHSO would welcome the Committee's support for including these measures in the legislation that will follow the NHS Integration and Innovation White Paper. We would also welcome similar support for removing the out-dated MP filter and making other improvements in our Parliamentary jurisdiction when appropriate legislative opportunities arise.

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

As set out in PHSO's 2018-21 strategy, we are committed to publishing casework decisions online and we have been developing the systems, processes and technology that will make this possible. From the end of April 2021, we will start publishing decisions online on a new digital publishing system linked to PHSO's website. This will provide greater transparency and allow complainants, Select Committees, researchers, policy-makers, and other members of the public to see the recommendations that PHSO makes when we find that an organisation has got something wrong and they need to put it right. Looking ahead, we plan to develop the digital publishing system further, and this includes publishing information about compliance with PHSO's recommendations.