Under the auspices of the International Ombudsman Institute

INTERNATIONAL OMBUDSMAN INSTITUTE

Ombudsman Peer Review of The Parliamentary and Health Service Ombudsman, UK

THE GREEK OMBUDSMAN
INDEPENDENT AUTHORITY

The State Comptroller and Ombudsman of Israel

Housing Ombudsman Service

MANCHESTER 1824
The University of Manchester

Ownership of report

Whilst PHSO has been given the opportunity to comment on this report, it was prepared independently and intellectual ownership remains with the Panel.

Conducted under International Ombudsman Institute (IOI) Guidance and by accredited peer reviewers

Chaired by Dr Andreas Pottakis (Panel Chair, Greek National Ombudsman and Chair of IOI European Board), with Mattanhayu Englman (State Comptroller and Ombudsman, Israel) Andrea Keenoy (Chief Operating Officer, Housing Ombudsman, UK), and Professor Robert Thomas (Professor of Public Law, University of Manchester, UK) report author.

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Panel biographies

Andreas I. Pottakis

Andreas I. Pottakis studied Law at the Universities of Athens and Oxford where he was awarded a doctorate (D.Phil.) in EU Public Law. He has lectured at various European Universities, in the UK, in Italy, in Turkey and in Greece where he has also pursued a career as a lawyer before the Supreme Court. He is a professor and the Provost for postgraduate studies at the European Law and Governance School (ELGS), and the Alternate Director of the Academy of European Public Law. From 2011 until 2015, Andreas Pottakis served as legal advisor to the General Secretariat of the Hellenic Government, while from 2015 until early 2016 he was appointed at the position of Head of the Legal Office. He has published extensively on a wide range of areas, including, inter alia, European Public Law, Comparative Law, Constitutional and Administrative Law, and the legal protection of Human Rights

Andreas Pottakis was elected by Parliament to the position of the Greek Ombudsman in late July 2016 and serves a term of 6 years. In late 2017 he was elected Regional Director at the International Ombudsman Institute (IOI-Europe) and in 2018 President of the Association of Mediterranean Ombudsmen (AOM), effective from 2019. In the elections of the IOI-Europe in 2019, he was elected first among his counterparts in IOI's European region, leading to his automatic participation in the Board of the International Network IOI, while in 2020 he was elected to the position of President of IOI-Europe.

Matanyahu Englman

Matanyahu Englman is the State Comptroller and Ombudsman of Israel from July 2019. In 2021 Mr. Englman was elected as the next President of Eurosai. He is now acting as the first Vice President, and by 2024 he will enter to his role as president. Before Mr. Englman was appointed as the State Comptroller and Ombudsman, he was the Director General of the Council for Higher Education in Israel, Executive Vice President and Director General of the Technion, the Israel Institute of Technology, Chairman of the Directors' Forum of the Heads of University Committee, and C.E.O. of Shoham Local Council. Mr. Englman is a CPA, and holds a bachelor's degree in economics and accounting and a master's degree in business administration, both with honours, from the Hebrew University of Jerusalem.

Andrea Keenoy

Andrea joined the Housing Ombudsman Service in September 2015 as the Director of Finance and Corporate Performance. She was Interim Housing Ombudsman from 31 August 2018 to 1 September 2019, and was then appointed as Chief Operating Officer.

She is a qualified Chartered Accountant and previously worked for the National Audit Office (NAO), auditing a range of government departments and their arm's-length bodies. During her time at the NAO, she was also part of the technical support team, leading on a range of interventions aimed at improving governance, and was seconded to the House of Commons Scrutiny Unit.

Outside of work, Andrea is an Associate Governor at a maintained primary school, attending its Finance and Resources Committee.

Robert Thomas

Robert Thomas is a Professor of Public Law at the University of Manchester. He is an expert in administrative law and has published widely in the area. He is also a member of the Administrative Justice Council.

Executive summary

This is the report of the second independent peer review into the Parliamentary and Health Service Ombudsman (PHSO) and the first in the world to be undertaken under the International Ombudsman Institute framework with accredited reviewers. In 2018, the first peer review concluded that, having faced organisational crisis, PHSO was moving out of 'critical care' into 'recovery'.[1] This review finds that PHSO is now a substantially stronger organisation than it was at the time of the first peer review in 2018. It is an efficient, enhanced and effective modern Ombudsman service, which provides significant value for its stakeholders. PHSO has improved its internal controls and introduced various initiatives, such as its Complaint Standards, its Academy and accreditation training, new assurance processes and the appointment of a significant number of new staff. At the same time, the work and role of PHSO is made more challenging for the organisation and less accessible to the public by the lack of much-needed reform of its statutory powers and framework.

The conclusions in this report arise from an independent peer review conducted by a four-member panel ("the Panel"). The Panel was chaired by Dr Andreas Pottakis (the Greek Ombudsman and President of the International Ombudsman Institute (IOI) Europe) and included: Matanyahu Englman (State Comptroller and Ombudsman of Israel); Andrea Keenoy (Chief Operating Officer of the Housing Ombudsman, whose remit covers England), and Robert Thomas (University of Manchester). Members of the Panel were selected from a general list validated as peer reviewers by Dr Tom Frawley, former Northern Ireland Ombudsman and Vice-President of IOI. The European Board of the International Ombudsman Institute went on to confirm these validations. As recommended by the Public Administration and Constitutional Affairs Committee (PACAC), two of the Panel members selected are trained and experienced auditors.

In conducting its review, the Panel examined a large volume of documentation and conducted a two-day visit to PHSO's offices to gain an in-depth insight into the work of the organisation. The resulting report reaches the following conclusions on five key areas:

Progress since the peer review of 2018

PHSO has made significant progress since the 2018 peer review. It has core strengths in terms of its leadership, enhanced training and accreditation, the development of Complaint Standards for the NHS and Government departments, professional development of staff, and IT. PHSO's new quality assurance processes, the introduction of its Academy and accreditation have set new and high standards

[1] P Tyndall, C Mitchell, and C Gill "Value for Money Study: Report of the independent peer review of the Parliamentary and Health Service Ombudsman" 12 November 2018.

in the Ombudsman sector. The Panel found scope for improvements. These are detailed in this report. They include, for example, the potential for more coaching for caseworkers sitting between probation and senior caseworker roles and that investigation reports sent to complainants should refer to them personally rather than being anonymised. However, these points are made against the background of our overall positive assessment that PHSO provides a high-quality service and is a robust institution.

The COVID pandemic

In 2020, PHSO paused its handling of health complaints in light of the intense pressures and challenges on the NHS given the COVID pandemic. This in turn led to a backlog of outstanding complaints. We note that the Inquiries line continued throughout. We think that the decision to pause the consideration of health complaints was reasonable given the unprecedented and acute challenge for the NHS. PHSO has reduced the backlog, and it will be reduced significantly further over the next 12 months. PHSO should continue to monitor the size and trajectory of the queue in the meantime.

Value for money

PHSO's approach to understanding and assessing its value for money has developed significantly since the 2018 peer review. PHSO has introduced equity as an additional principle to complement the '3Es' of economy, efficiency and effectiveness. We recognise the difficulties in assessing the impact of PHSO in terms of improving public services – a key aspect of its effectiveness. Nonetheless, as with the 2018 peer review, we think that more could be done to make use of qualitative and contextual information about PHSO's impact and effectiveness to reflect that it is not delivering a transactional service.

PHSO's Corporate Strategy (2022-25)

PHSO's Corporate Strategy 2022-25 identifies the following strategic objectives: improving access to justice; providing a high quality, empathetic and timely service in accordance with international ombudsman principles; and contributing to a culture of learning and continuous improvement, leading to high standards in public services. The strategy also details specific aims and how PHSO will know that they are being achieved. The Corporate Strategy represents the next stage of PHSO's journey of continuous improvement. We found that this is a robust and well-thought through plan. PHSO's public profile, whilst no lower than that of comparable bodies, potentially constitutes a barrier for some complainants and we concluded that PHSO needs to promote better awareness of its service.

The Panel welcomed the commitment to establish a panel of users and members of the public who can provide feedback upon and inform PHSO's work. We suggested that PHSO could seek to provide a more empathetic service for complainants by adjusting its publication approach so that the investigation reports sent to complainants are not anonymised. We also thought that PHSO should consider taking more steps to understand the potential demand implications of its increased public awareness and accessibility and to plan for these accordingly. This should take particular account of people and communities whose circumstances make them vulnerable. We also suggested that PHSO provide clear reporting in an easily understandable and accessible way on progress with delivering the strategic plan.

The Venice Principles and reform

The 'Venice Principles' lay down a set of international standards and principles on the protection and promotion of Ombudsman institutions. These have been accepted by the UK, as a member of the Venice Commission of the Council of Europe. They were also adopted by the UN in a motion co-sponsored by the UK Government. In several respects, PHSO's legal framework complies with the 'Venice Principles', but not in other respects. PHSO's statutory framework is now out of date and widely seen as being unnecessarily restrictive. PHSO is also out of line with other UK Ombudsman offices, which possess powers that PHSO does not. This means that citizens in some parts of the UK do not have the same rights as others. We are aware that reform of the Ombudsman is a long standing and unresolved issue, although it has become an increasingly urgent matter which makes the work of PHSO more difficult. PHSO is doing everything it can reasonably do to make the argument for reform. What is required is action from the UK Government and Parliament. Any reform must maintain PHSO's direct reporting line into Parliament to preserve its absolute independence from Government.

Peer review terms of reference

The Panel's terms of reference were agreed by PHSO and the Chair of the Panel. These terms of reference required the Panel to consider the following matters:

(i) Progress since the peer review of 2018, and the steps taken to address the suggestions for improvement made in that review;

(ii) The steps taken to deal with the COVID pandemic, including consultation and communication, flexible working, and demand management;

(iii) Value for money (VFM) of PHSO, in particular a review of the formulation developed by PHSO's Audit Committee with help from the National Audit Office, to develop VFM standards, and the centrality of applying value to non-investigation issues (publications, systemic reports, policy development (e.g. Complaints Standards) and outreach work.

(iv) A review of the newly-adopted Corporate Strategy (2022-25) and its three strands for implementation – raising awareness of the Ombudsman service, delivering a high quality, empathetic service in line with international good practice, and contributing to a culture of learning and continuous improvement, leading to higher standards in public service and administration.

(v) A summary focus on how the mandate of PHSO matches the Venice Principles and the consequent assessment of the need for long-promised legislative reform in the light of any perceived deficits.

This report is structured in light of the above topics.

Peer Review Methodology

By way of background, the role of any Ombudsman is principally to investigate people's complaints about Government and public services and also to make wider recommendations to improve those services. PHSO handles complaints about UK central Government departments and other public bodies. It also handles complaints about the health service in England. It is an amalgam of two offices: the Parliamentary Commissioner for Administration (which was established in 1967) and the Health Service Commissioner (first established in 1973, though most powers are drawn from the later Health Service Commissioners Act 1993).

The peer review included an onsite visit to PHSO by the Panel on 20-21 October 2022. In advance of the onsite visit, we were provided with a wide range of documentation by PHSO, including both publicly available documents and internal PHSO documents. The onsite visit comprised a series of meetings with and presentations by PHSO staff. These sessions covered a wide range of topics regarding PHSO's work, including: its casework; strategy and communications; finance, value for money, governance, assurance and risk; clinical investigations; quality controls; the Complaint Standards; and assurance processes. We held two separate and confidential meetings with two of PHSO's non-executive directors and a meeting with its senior independent director. We also held separate and confidential focus group sessions with: PHSO staff; public bodies within the jurisdiction of PHSO; and a voluntary group of complainants selected by an independent agency. We met with the National Audit Office director responsible for the oversight of PHSO accounts and with RSM, PHSO's internal auditors. We put questions to PHSO staff to which they responded. We probed and challenged PHSO senior leadership in various respects. They listened to us and responded by providing detailed explanations and engaging in discussions. We were given access to all the information we requested. Overall, we were provided with every assistance by PHSO staff. We were welcomed with an attitude of openness and transparency. The preparations for the peer review by PHSO were professional, thorough and serious.

Data about PHSO's performance since 2018[2]

Table 1: Incoming demand for PHSO's service, 2018-2022

Volumes Of Enquiries & Complaints Accepted	Year or Quarter			
	2018-19	2019-20	2020-21	2021-22
Total Enquiries Dealt with by PHSO's Contact Centre Including phone calls, emails, post & webforms	112,262	103,965	79,249	122,367
Total Complaints Accepted for Consideration Complaints accepted including those re-presented	29,264	31,365	24,842	36,248

[2] Following discussions with the Public Administration and Constitutional Affairs Committee (PACAC) in 2020, PHSO changed the way they present information about their performance. The data is now clearer and easier to understand as well as reflecting changes to their casework process. It also means that data presented in earlier years is not always directly comparable.

Table 2: Decisions made by PHSO, 2018-2022

Decisions Made - by Complaint Stage	Year or Quarter			
	2018-19	2019-20	2020-21	2021-22
Decided Following Initial Checks	21,672	23,141	18,689	29,213
Resolved by Mediation	N/A	14	14	29
Decided Following Primary Investigation	6,332	6,530	3,864	6,760
Decided Following Detailed Investigation	1,837	1,210	557	612
Total Complaint Decisions Total of all complaint decisions across our processes	29,841	30,895	23,124	36,614

Table 3: Detailed investigation decisions, 2018-2022

Upheld & Partly Upheld - Detailed Investigation Decisions	Year or Quarter			
	2018-19	2019-20	2020-21	2021-22
Total All Jurisdictions (number)	746	650	338	394
Government departments and agencies (number)	38	46	38	45
Health bodies (number)	708	604	300	349
Upheld Rate % Complaints upheld and partly upheld as a percentage of all detailed investigation decisions	41%	54%	61%	64%
Upheld Rate - Government departments and agencies % Complaints upheld and partly upheld as a percentage of all detailed investigation decisions about government departments and agencies	33%	54%	51%	56%
Upheld Rate - Health Bodies % Complaints upheld and partly upheld as a percentage of all detailed investigation decisions about health bodies	41%	54%	62%	66%

Progress since the 2018 Peer Review

In considering PHSO's progress since the 2018 peer review, we looked at a range of matters. We were provided with details of the transformation of PHSO during the years 2018-21. This has included: implementing its Clinical Advice Review by closer integration of clinical advisers into the casework process; focusing on professional development and the establishment of a training academy to ensure caseworkers have the training and skills necessary for their roles, and offering an innovative accreditation programme for senior caseworkers; the introduction of mediation into casework as an alternative approach for appropriate cases; the introduction and publication of quality standards and scores into casework, which complement PHSO's Service Charter.

To turn to more specific matters, we will consider the following: the balance between generalist and specialist casework models; improvements to PHSO's case management system and IT strategy; and the level of manager-sign off on casework decisions.

In 2017, PHSO moved to a generalist casework model; casework staff are trained to handle most types of cases, in line with best practice in terms of efficiency and effectiveness across the Ombudsman sector. At the same time, PHSO has recognised the need to build and retain *specialist* knowledge to handle certain types of cases effectively. All casework teams undertake some standard health cases, currently the majority of PHSO's work. There are also specialist teams handling the increasing number of Parliamentary cases and cases related to Women's State Pensions and Continuing Health Care and also COVID-19. The intention is to achieve an appropriate balance between generalist and specialist casework so that complaints can be investigated with both insight and professionalism. PHSO has also gradually expanded the knowledge and expertise across its senior casework teams to handle complex, high-risk and systemic cases to ensure both sustainability and continuity of expertise. Training is complemented by a specialist knowledge internet-based platform. Key staff are identified as subject or department experts and act as the first point of contact for casework staff. The Panel concluded that PHSO has sought to balance generalist and specialist casework in light of the demands placed upon it to attain an appropriate mix of skills and expertise.

As regards IT, since the last peer review, PHSO has introduced a new Casework Management System (CMS) based on the Microsoft Dynamics CRM system to meet its specific needs. It has ensured that its ICT and data strategies directly align with its corporate purposes. The Panel concluded that there have been significant improvements in PHSO's IT capability. We also thought that the following matters could usefully be given attention: (1) it would be profitable to introduce a direct interface between PHSO's IT systems and those of the NHS. This has the potential to improve significantly and streamline the investigation procedure. (2) The secure egress email system should be replaced. This matter is on PHSO's agenda. This email system for external use is not user-friendly and may prevent complainants

who have a lack of digital orientation from accessing documents and reports sent to them. This is particularly important given PHSO's work in reaching out to vulnerable communities.

Another change has concerned the staff level at which decisions are signed-off. At the time of the 2018 peer review, all PHSO decisions were signed off by a manager. PHSO has since developed an accreditation approach for senior caseworkers. PHSO's Advanced Certificate in Professional Practice for Ombudsman senior caseworkers is the first of its kind in the Ombudsman sector. The aim and outcome of the accreditation programme is to improve the consistency and quality of PHSO's work. Accredited senior caseworkers can take delegated decisions on low- risk cases, which represent the large majority of the cases that they consider. We also heard that PHSO's plans to delegate further decision-making to caseworkers were aligned with the development of decision quality standards and measures. In this way, PHSO is able to ensure that the quality and consistency of its decisions is high across all areas.

There have been other initiatives and developments. PHSO has increased its use of mediation in health cases. The number of mediations is relatively low compared to the overall caseload. Nonetheless, mediation has some role to play, in appropriate cases, by enabling people to have their concerns addressed. There has also been a significant increase in the number of new caseworkers recruited and appointed. PHSO now has 30% more caseworkers than it did compared with 2019-20. We also heard how PHSO performs an important role in advising people about where to direct their complaints. It receives about 70,000 enquiries per year from people who need advice and signposting.

As regards professional development, PHSO has established a training academy to ensure that caseworkers possess the training and skills required for them to perform their role. The training programme includes: comprehensive induction and development programmes; accreditation for senior caseworkers; and coaching and mentoring programmes. Staff told us that they appreciated this. PHSO intends to build upon this by further embedding its professional learning and accreditation programme for its staff. The wider agenda is to make case-handlers progressively more professionalised. The Panel found that PHSO's work on professional development is beyond and above those of other Ombudsman schemes. The introduction of the Academy for training new caseworkers for 10 months is a leading innovation and goes beyond what other Ombudsman offices internationally both provide and require. We did, however, find that some of the staff we spoke with highlighted the need for coaching and development after they completed the Academy.

We also considered the transparency of PHSO. The Ombudsman publishes a wide range of information in its annual report, website and other publications. PHSO has increased transparency of the organisation itself and its casework through: meetings and events with service users and stakeholders; regular media appearances; 'Radio Ombudsman'; and an online portal for the routine and

monthly publication of PHSO case summaries. The Panel found that PHSO publishes information on its findings and its performance.

Since 2021, PHSO has published its investigation reports online. We recognise that this is an important development in the increased transparency of PHSO. People are able to view investigation reports and to search them by reference to the public body concerned and the generic nature of the issue complained of. The Panel welcomed the publication of investigation reports. We concluded that PHSO should make every effort to publish all of its decisions in the interests of transparency. If, for some reason, it is not possible to publish the decision itself, then a summary of the investigation and its outcome should be published.

The Panel highlighted how investigation reports are presented to complainants. PHSO's practice is that complainants receive an anonymised version of their final investigation reports. This practice has arisen because of the way these reports are written and then automatically placed on PHSO's website for publication purposes. As the same report is provided to complainants, they receive an investigation report which refers to them anonymously as, for instance, 'Mrs D' as opposed to using their personal name. We fully recognise the need for investigation reports placed on PHSO's website to be anonymised. However, we did not think that investigation reports sent to complainants either needed to be or should be anonymised. We were informed that the covering letter sent by PHSO to complainants addresses them by name. It answers any points they may have made about the draft report and explains in writing why the accompanying investigation report is anonymised. However, we concluded that sending anonymous reports to complainants was an impersonal means of communication. We therefore recommended that the investigation reports sent out to complainants should refer to them by their personal name. Investigation reports published online should, of course, continue to refer to complainants anonymously.

The Panel also concluded as follows:

- Letters to complainants should be written in a manner that is readily comprehensible by people without a professional or medical training or background.
- Face to face meetings, including over video link, with complainants should be encouraged, especially in difficult cases.
- Complainants should be regularly updated on the progress of their complaints and the investigation.

As regards staff engagement, we found that PHSO's current leadership has focused upon transformation and has recognised in particular the need to engage with and listen to its staff. Members of PHSO staff are encouraged to speak up and to share their ideas, concerns and feedback, and to challenge senior leaders and help them to listen. Staff morale and satisfaction, as measured by PHSO's staff survey results, have significantly improved. Staff engagement levels have increased by 17 points since 2016. PHSO now has a strong human resources team. It has also established a 'Freedom to Speak Up Guardian' who enables staff to share their ideas, concerns and feedback, and to challenge senior leaders and help them to listen.

More recently, the Ombudsman has addressed the issue of hybrid working through a pilot, working with staff in partnership to look at evidence-based ways of effective working. This has been supported by research and evaluation, to develop an evidence base to inform PHSO's future approach to hybrid working. The staff we spoke to in the confidential session were positive about their work and committed to it. They recognised the importance and seriousness of the matters they deal with. We heard that senior caseworkers and PHSO lawyers provide assistance to caseworkers and proactively organise additional learning sessions as and when the need arose.

The Panel found that some of PHSO's staff felt that while they are included in engagement sessions and discussions with senior colleagues, enabling them to express their opinions, they are not informed about how their observations are subsequently manifested in the formulation of the office's policies and strategies. Furthermore, some of the staff felt that they were not adequately associated with the office's vision and the manner in which the office incorporates its policy into the day-to-day work of its staff. Having said this, staff were all full of admiration for the office's leadership and expressed satisfaction with the office's present work programme.

As regards outreach and external engagement, PHSO has been working in partnership with public bodies to improve frontline complaints handling in public services. The PHSO has developed Complaint Standards in order to improve and assure the quality of the initial consideration of complaints by public bodies. If the initial handling by public bodies is inadequate or poor, this will result in barriers to learning from mistakes. The public bodies with which we spoke very much welcomed PHSO's introduction of the Complaint Standards. Related actions include: establishing a liaison team to conduct effective communication and visits to hundreds of front-line bodies within PHSO's jurisdiction; a two-year research project entitled *Making Complaints Count* (HC 390, 2020) on the current state of complaints-handling by bodies in jurisdiction; and the introduction of Complaints Standards for the NHS and central government. The NHS Complaint Standards have been piloted in partnership with 11 NHS pilot organisation and around 70 early adopters. We were impressed by this work and its reception and acceptance by the public bodies with which we spoke. PHSO's aim is for the Complaint Standards to be considered as the benchmark for complaint-handling by Government and public bodies.

The Panel was particularly impressed by PHSO's Complaint Standards. We view this as a commendable endeavour to improve the quality of complaint-handling by public bodies. PHSO has moved into an area that, in general terms, was previously accorded a relatively low-level of priority by government and public bodies. PHSO has recognised expertise in the standards of complaint-handling and it has worked closely with public bodies to help them improve their initial handling of complaints. We think that this is valuable and important work and has great potential. The Panel believes that it is important for PHSO to track the progress of public bodies in adhering to the Complaint Standards and publish this information.

The Panel recognised that PHSO is currently in the initial stages of making its service more accessible to vulnerable populations. The Panel recommended that PHSO continued pursuing this end, given that a significant proportion of the population is unaware of the existence of PHSO and therefore also how to contact it or use its services. We think that PHSO could do much valuable work in this regard by analysing statistical data on the complaints it receives, conducting surveys and communicating with stakeholder organisations.

PHSO has engaged with Government and public bodies. At the same time, we concluded that PHSO could do more outreach work to raise its wider public profile. Public recognition of PHSO is low, much lower than it should be for such an important body, though its public recognition rate is in line with comparable organisations in the UK. We recognise the efforts made by PHSO leadership to make the office as visible as possible, including 'Radio Ombudsman'. However, we think that PHSO needs to do more in this respect. This could include targeted outreach work with particular stakeholders who represent cohorts of the population that make few complaints to PHSO.

Panel observations

Overall, we found that PHSO has made significant progress since the 2018 peer review. It has core strengths in terms of its leadership, enhanced training and accreditation, professional development and IT. PHSO's new quality assurance processes, the introduction of its Academy and accreditation set a new and high standard in the Ombudsman sector. The panel concluded that these processes are robust and of high quality. The accreditation process led by the office is also highly welcome and impressive, making it possible for senior staff members to adopt a more independent and effective mode of working. This is without doubt an impressive teaching process, which improves the quality of investigations of the senior staff, while at the same time shortening the investigation processes by means of delegating authority to senior staff. In terms of improvement, the Panel thought that PHSO could provide more coaching for caseworkers sitting between probation and senior caseworker roles. Some staff note that while they received continuous support while they were at the Academy, they received less than they would have liked after joining their work teams. We also thought that PHSO's intake team should be trained to the same extent, a matter that we were informed is on PHSO's agenda. The Panel also thought that PHSO's quality assurance and assessment staff possess a great deal of current experience in the investigation of complaints to enable them to quality assure investigations and reports effectively.

The Panel also concluded that PHSO staff who respond to formal contestations about complaints and are in contact with the complainants should be members of its (separate) Ombudsman Assurance Team (and not the original complaint investigators), so that the complainant challenging a decision on a complaint can see that the matter has been handled and examined by a separate, designated

unit. We also recommended that in future investigation reports sent to complainants should refer to them personally and that PHSO do more to raise its wider public profile.

PHSO's response to the COVID pandemic and its aftermath

We now consider the steps taken by PHSO during the COVID pandemic. Like all public services, PHSO was affected by the COVID pandemic. At the beginning of the pandemic, PHSO paused its work on health-related complaints given the pressures on the NHS to respond to the crisis. Its work on health complaints restarted in July 2020. Inevitably, the pandemic negatively impacted upon PHSO's performance. As occurred in other workplaces, with the introduction of a national lockdown in March 2020, all PHSO staff moved to full-time homeworking. Given the situation and until arrangements could be made for remote access to its system or for post to be scanned and sent to caseworkers electronically, there was a period during which enquiries were processed, but not counted. PHSO took appropriate actions to mitigate the risks. We heard from staff that they were able to continue their work remotely.

The principal 'legacy' issue of the pandemic has been the accumulation of a backlog of complaints waiting to be investigated. This backlog reached a height of 3,200 cases waiting investigation in 2021. Since the end of the pandemic, PHSO has received around 24 per cent more complaints than it received in the last full pre-pandemic year (2018/19). It has taken various steps and measures to address the situation. This has included: the recruitment and training of over 80 new caseworkers in 2021-22 alone, with a further 16 by the end of June 2022; the delegation of decision-making to accredited senior caseworkers; the introduction of quicker routes to resolve or discontinue more straightforward complaints; the introduction of mediation and specialist skills; improved process efficiencies; and improved quality of decision-making. The effect of this has been to reduce the backlog from 3,200 to 1,700 cases awaiting investigation by September 2022. PHSO expects the backlog of complainants to be further reduced toward the end of 2023. We think this is a reasonable course of action. We would also note that during the pandemic, PHSO published a significant report entitled *The Art of the Ombudsman* and special reports on NHS imaging services and Continuing Health Care.

Panel observations

In considering PHSO's response to the pandemic, it is necessary to recall the national situation as it was in March 2020 and in particular the acute challenge for the NHS. Overall, our view is that the decision to pause health complaints during the pandemic was, in retrospect, the only sensible decision that PHSO could have taken given the intense and unprecedented pressures and challenges for the NHS at the time.

Since the lifting of lockdown restrictions, PHSO has focused upon reducing the backlog of outstanding complaints. It hopes to reduce the backlog much further in one year. We think that PHSO's current focus on reducing the backlog is both necessary and appropriate, and PHSO should continue to monitor the size of the backlog in the meantime. Overall, we conclude that PHSO's response to the pandemic has been reasonable given the circumstances.

Value for Money

We now consider how PHSO approaches the question of its value for money. As a public body funded by the taxpayer, PHSO is required to demonstrate that it makes good use of public money. There are, though, challenges and complications in terms of identifying the most appropriate means of assessing and measuring value for money given that PHSO both investigates individual complaints and seeks to also engages in a range of other activities designed to improve the delivery of public services and promote good administration.

At the time of the 2018 peer review, PHSO used cost-per-case as a means of measuring its value for money in terms of the traditional principles of economy, efficiency and effectiveness. However, the 2018 peer review concluded that using cost-per-case only provided a very limited way of measuring and understanding the degree to which it provides value for money. That review concluded that 'value for money' requires significant contextualisation and sensitivity in terms of its interpretation. It also excluded or underplayed a large amount of the added value that Ombudsman offices deliver for their stakeholders. The 2018 peer review recommended that PHSO develop different methods of assessing value for money.

We were informed that PHSO accepted and recognised the findings of the 2018 peer review and had responded to them. PHSO now takes the position that an assessment of its value for money involves a nuanced judgement – as opposed to a binary yes-no answer. This approach involves the consideration of both qualitative and quantitative data and information. We were also told that PHSO's approach to value for money has evolved significantly since the 2018 peer review. Its audit and risk assurance committees have worked with internal auditors and the National Audit Office to develop its understanding of how to measure value for money. PHSO recognises that any assessment of its value for money must take into account the complexity of its cases, their impacts and the office's effectiveness. A rounded assessment must also take into account not just the conventional value for money values of efficiency, economy and effectiveness, but also a fourth value: equity, that is, the extent to which PHSO is able to reach all of the people that it should and who need its services.

We recognise that a particular difficulty for PHSO concerns how to measure and evaluate its effectiveness in terms of its impact upon public bodies. For instance, in its systemic and policy insight reports, PHSO issues recommendations designed to improve public services. There are inherent difficulties in assessing the impact of such reports in improving public services and promoting good administration, which arise from the uncertainty of isolating the influence of the Ombudsman compared with other causes and factors. Another complication is how to calculate the value of PHSO's contribution in terms of both its economic and social benefits. A related matter is that while PHSO's recommendations are almost always accepted, this is not universally the case. Government may decide not to accept PHSO's recommendations thereby limiting its effectiveness. However, this is a

matter outside the control of PHSO as it is an issue for government and public bodies.

We were told that future development of a framework for assessing PHSO's value for money will include a greater focus upon equity, meaning the ability of people to access PHSO's service. Further, PHSO has developed a three-part approach to help it make an overall judgement of its value for money and has received public recognition for this by the National Audit Office. This comprises: a set of metrics which it monitors over time; independent assessment through peer review; and HMT's Public Value Framework, which includes a qualitative assessment including, for instance, strategic planning, the measurement of benefits, financial planning and the experiences and participation of users.

Despite the real difficulty for PHSO in terms of assessing its contribution to wider systemic improvements across the public sector and the savings achieved as a result, it is nonetheless apparent that PHSO does exert impact. We were presented with examples of high impact investigations. This included a complainant being refunded £250,000 because of a failure by a Clinical Commissioning Group in assessing Continuing Health Care costs; recurring failings in reporting and acting on X-rays and scans, which led to delayed diagnoses and poorer outcomes for patients; the failure by the Department for Work and Pensions to communicate changes in the Women's State Pension age; the failure of the same Department to pay compensation to over 118,000 people whose disability benefits were wrongly calculated; the death of a baby following errors in both the care provided and the hospital trust's complaint-handling. We recognise that it is difficult to assess the value for money provided by these reports, but that nonetheless, they provide clear indications of the impact of PHSO.

Panel observations

Our overall view is that PHSO has strong financial and risk management, which confirm the overall value for money provided by PHSO. We found that there has been a significant improvement since the last peer review as regards PHSO's reporting of its activities to different audit bodies. PHSO makes regular reports to its board, which asks challenging questions and requires the senior leadership team to focus on issues troubling board members, such as the backlog of outstanding complaints. It is also scrutinised by its internal auditors and by the National Audit Office. The Panel also recognised the importance of PHSO agreeing a three year and wide-ranging budgetary framework, which enables the intake of staff and provides budgetary certainty.

The Panel welcomed the work that PHSO has undertaken to develop better measures of its value for money in terms of its impact and effectiveness. There will always be areas of uncertainty in assessing impact and effectiveness and in drawing associations or causal links. There are also intrinsic difficulties in trying to calculate the public value of its contribution. Nonetheless, it is likely that the work of PHSO supports a range of positive changes in government and public

services, though this occurs through ways that cannot be easily captured through a cost-benefit calculation. We think that the inclusion of equity as a measure of value for money is correct and important. PHSO highlighted the importance of equity in terms of its approach to improving access to justice, which it is part of its Corporate Strategy 2022-25. In this respect, PHSO is on a developing and ongoing journey in terms of refining its approach to value for money.

We think it is important to recall that the 2018 peer review highlighted the need for a more qualitative and contextual approach, recognising the multi-dimensional nature of what value means in an Ombudsman context, including the value delivered for complainants, Parliament, public services and citizens at large. Building upon this, we think that there is scope for PHSO to do more to evidence its impact. It could collect together and present information which would assist in terms of enabling others to form a more rounded understanding and appreciation of its impact and effectiveness. PHSO already does this, to some degree. For instance, it has published information concerning the amounts of financial compensation secured for complainants and the actual or likely numbers of people affected as a result of findings in systemic investigations. The Panel thought that PHSO could also publish responses by government and public bodies to its systemic reports; and weblinks to relevant Parliamentary debates and select committee evidence sessions and reports concerning the Ombudsman's reports. To illustrate the point, PHSO's investigation into DWP's handling of migration to Employment and Support Allowance was discussed in the House of Commons. In this way, PHSO played an important function in terms of enabling the public accountability of government, an important public good. In its Corporate Strategy, PHSO intends to 'monitor the implementation of our recommendations, identify gaps and develop strategies for improving levels of compliance'. We think that information generated by this could usefully be included also. PHSO could also publish information on its outreach work and updates on the implementation of the Complaint Standards.

The Panel concluded that PHSO's annual report could include more information on the outcomes of complaints and should also include information that is of more direct interest to the public.

The annual report should emphasise one or two data which will interest the wider public and be the focus of publicity.

The value of financial remedies secured by PHSO and published in its annual report does not reflect the financial implications of the Ombudsman's work. For example, if PHSO has decided that the body must reimburse the complainant with a considerable sum of money, and the decision also has implications for a large number of people, the financial implications of the decision should be calculated in a comprehensive manner, even if the public body has not yet consented to refunding the money to all the persons involved.

The Panel also concluded that PHSO could publish more information about the characteristics of complainants, for example the breakdown of complainants by education, gender, area of residence or religion, and with cross-cutting data relating to different population groups.

PHSO's Corporate Strategy 2022-25

We now consider PHSO's Corporate Strategy 2022-25, an integral part in the next stage of its journey of continuous improvement.[3] The strategy identifies three strategic objectives for the Ombudsman. These are as follows: first, people who use public services should have a better awareness of the role of the Ombudsman and be able to access its service easily; second, people that PHSO works with should receive a high quality, empathetic and timely service, according to the international principles and standards of ombudsman services; and, third, PHSO will contribute to a culture of learning and continuous improvement, leading to high standards in public service.

These high-level strategic objectives are underpinned by more detailed and specific aims. For instance, in order to achieve the first objective – ensuring that people using public services have a better awareness of the role of the ombudsman and can easily access its service – three more specific aims are identified. PHSO will: remove barriers to its service; improve public awareness of what it does and provide clarity about its role so that people can make informed choices; and focus its resources to make sure right decisions are made at the right time. The other two strategic objectives have their own specific aims as detailed in the strategy document.

Each of the aims – for each of the three objectives – are then, in turn, underpinned by various further actions which PHSO will undertake to enable it to understand the degree to which each aim is being achieved and hence how it is achieving its strategic objectives. For instance, the first strategic objective – ensuring that people using public services have a better awareness of the role of the ombudsman and can easily access its service – has its first aim as removing barriers to PHSO's service. In order to know whether this is happening, PHSO will: (i) undertake research to understand what prevents people from bringing their complaints to it, which groups of people are less likely to do so and why and develop and implement a programme of engagement in response to the findings; (ii) work with partners in the justice sector and with advocacy groups to improve signposting and referrals and understanding of common themes so that the Ombudsman can identify how it can work together with such groups to overcome barriers; and (iii) the Ombudsman will highlight opportunities for legislative reform so it can better support people who use public services, and adjust its ways of working where necessary. There are similar specified actions for the other strategic objectives and their accompanying aims.

The 2022-25 Corporate Strategy is necessarily a high-level document. It is, in turn, underpinned by PHSO's transformation programme. This is comprised of three key strands: first, improving casework, particularly with regard to using data to improve its services (including how PHSO gathers and analyses evidence of systemic failings) and determine how complainants and organisations access

[3] PHSO's Corporate Strategy 2022-25

information on complaints; second, addressing barriers to justice by improving public awareness of its service and engaging more effectively with the public and user communities, as well as with external stakeholders to improve signposting; and, third, developing its culture as a modern, high-performing and learning organisation, with the right skills, people and processes. PHSO also publishes an annual business plan detailing all of its activities to deliver the objectives of the 2022-25 strategy. The business plans will include an evaluation to identify and measure impact.

Panel observations

The Panel welcomes PHSO's Corporate Strategy and transformation plan. They represent PHSO's considered views as to its strategic goals and how it can best deliver them. Given the current level of public awareness of PHSO, it is important that the office seeks to promote better awareness of its service and to ensure that people can more easily access them. This should focus in particular on accessibility for people and communities whose circumstances make them vulnerable. We recognise the importance of PHSO's media and communications work and its efforts to secure more support from communities and MPs. We found that the strategy rightly emphasises further external engagement with stakeholders. We also welcome the commitment to establish a panel of users and members of the public who can provide feedback upon and inform its work. We think this is an important development. We also thought that PHSO should consider taking more steps to understand the potential demand implications of its increased public awareness and accessibility and to plan for these accordingly. We also suggested that PHSO provide clear reporting on its actions in an easily understandable and accessible way; for instance, 'We said this … and we did this ….'.

Venice Principles

Our terms of reference require us to provide a summary analysis as to how the mandate of PHSO fulfils the 'Venice Principles', the Principles on the Protection and Promotion of the Ombudsman Institution. These principles were adopted by the Venice Commission in 2019.[4] The Venice Commission – in formal terms, the European Commission for Democracy through Law – is an advisory body of the Council of Europe on constitutional issues.[5] The Venice Principles lay down international standards for protecting and promoting the Ombudsman as a means of strengthening good administration and human rights. The UK Government co-sponsored a UN resolution to adopt the principles in December 2020.

We were provided with PHSO's own assessment of the degree to which its mandate fulfils the Venice Principles (see Annex A). We have considered this assessment and here provide our own thoughts and conclusions.

Overall, the statutory framework and powers of PHSO are, mostly, compliant with the Venice Principles, although there are varying degrees of compliance. However, there are various respects in which PHSO's statutory framework clearly does not comply with the Venice Principles. This is largely attributable to the fact that the Ombudsman – the then Parliamentary Commissioner for Administration – was established in the late 1960s while the Health Service Commissioner was created in the early 1970s, with refreshed powers in the 1990s. The upshot is that the statutory framework of what is now PHSO has been updated incrementally as opposed to having been the subject of wholesale reform and updating. PHSO's legal framework and powers have become increasingly out of date and inconsistent with those of other UK Ombudsman services and with international best practice. The UK Government has previously accepted the need for reform, in particular, the creation of a new public services ombudsman. A draft Bill was published in 2016, but was not progressed with owing to other developments.

Our focus here is the degree to which PHSO's current legal framework and role comply with the Venice Principles. We highlight the following as matters of particular and acute concern. Highlighting these matters prompts the question of why the UK Government entered into internationally binding commitments to the Venice Principles via the UN and Council of Europe, but has failed to enact these commitments so far.

First, the MP filter. People who complain to PHSO about UK central government and other public bodies must have their complaints referred to PHSO by an MP. No such filter applies to other public service Ombudsman schemes in the UK, which presents a challenge in that people in different parts of the UK do not have equal access to justice. Likewise, there is no such filter for most Ombudsman institutions around the world, including those represented on the Panel. This requirement – the MP filter – is long-standing and there are significant and persistent concerns

[4] The Venice Principles
[5] The Venice Commission

with it. MPs may inappropriately 'filter out' and not refer complaints to the Ombudsman that should indeed be investigated. The decision of an MP whether or not to refer a complaint is a matter of her or his discretion and practice is inconsistent. It is also the case that some people wanting to complain may be discouraged from doing so because of the need to go through an MP – for example, because it concerns a matter arising from the administration of a policy which that MP supported. A well-known example concerns people affected by Windrush and the hostile environment.

The MP filter is widely recognised to be an anachronistic requirement that disadvantages complainants and the redress of their grievances. The need to remove or otherwise modify the MP filter (for instance, by adopting a dual track approach) has been accepted by both the Government (in the context of the current Victims Bill and of the 2016 Public Services Ombudsman Bill) and by the Public Administration and Constitutional Affairs Committee. As regards the Venice Principles, it is quite clear that the nature and operation of the MP filter means that people raising complaints about central government do not have 'the right to free, unhindered and free of charge access' to PHSO. Accordingly, PHSO's framework does not comply with this principle. Of the complaints that PHSO receives but cannot look at because they do not come via the requisite MP referral, only 12% return to PHSO at a later date.

Second, own-initiative powers of investigation. These concern whether Ombudsman offices can proactively investigate a matter – for instance, potential systemic maladministration – even though no-one has complained to them of it. Some Ombudsman services have own-initiative powers; PHSO does not. It can only investigate a matter after a complaint has been lodged with it (under its parliamentary jurisdiction, the complaint must be referred to PHSO by an MP). By contrast, other Ombudsman services can investigate matters of potential systemic maladministration of their volition and without a complaint. The Northern Ireland Public Services Ombudsman and the Public Services Ombudsman for Wales both have own-initiative powers, meaning that citizens in different parts of the UK do not all enjoy the same rights. The Local Government and Social Care Ombudsman has the ability to investigate a matter of potential maladministration or fault, of which it becomes aware of during a prior investigation, despite the fact that no-one affected has made a formal complaint.

The Venice Principles require that an Ombudsman should have a 'discretionary power, on his or her own initiative or as a result of a complaint, to investigate cases with due regard to available administrative remedies.' Own-initiative powers are of particular value in relation to vulnerable people who are unwilling or unable to complain or in those instances in which a large-scale systemic problem arises within government, but which generates few, if any, complaints to PHSO. The rationale for own-initiative powers is that they enable the Ombudsman to investigate matters of maladministration and fault which it knows, or reasonably suspects, to exist, but which no-one has complained against. It is widely accepted that this is a key role for any Ombudsman. PHSO does not have this power and

therefore its statutory framework does not comply with the Venice Principles. The Panel concluded that the ability to undertake own initiative investigations is an important power that would enhance PHSO's capability to identify and correct harms and injustices caused to people by the failures of public bodies. Such powers would also enhance PHSO's visibility and improve awareness and understanding of the Ombudsman.

A third area of concern relates to the investigatory powers of PHSO. Such powers are essential for PHSO to perform its role effectively. One matter that has arisen recently concerns the degree to which the 'safe space' for medical professionals to raise matters with the Health Services Safety Investigations Body (HSSIB) constrains PHSO's investigatory powers. Under the Health and Care Act 2022, the HSSIB is unable to disclose material and information held by it for the purpose of its investigations into health safety. The rationale is that healthcare professionals need a 'safe space' in which they can feel able to disclose information about a medical problem without the risk that it could later be used in evidence against them. The restriction in the Health and Care Act 2022 applies to the release of such material and information to PHSO. The consequence of this is that PHSO is only able to access materials held within the HSSIB's 'safe space' if it first secures an order from the High Court. In contrast, the law in Israel, for example, protects the decisions made by the Ombudsman, so that they cannot serve as evidence in legal or disciplinary proceedings.

PHSO's view is that its exclusion from the safe space unreasonably limits its powers to investigate serious health complaints. It is important to situate the matter in the wider context of recent and significant health failures, including the deaths of babies at hospitals in Shrewsbury and East Kent. In 2021, the Venice Commission concluded that PHSO's exclusion from the 'safe space' violated the Venice Principle that the Ombudsman should, as part of its investigatory powers, 'have a legally enforceable right to unrestricted access to all relevant documents, databases and materials, including those which might otherwise be legally privileged or confidential'.[6] We agree.

A fourth matter concerns Complaint Standard Authority powers. As noted above, these powers relate to the ability of an Ombudsman to establish standards governing the initial handling of complaints by Government and public bodies and to then monitor the degree to which the handling of complaints by public bodies abides by those standards. Complaint Standard Authority powers are not specifically prescribed by the Venice Principles. Nonetheless, such powers have been increasingly conferred upon other UK other Ombudsman services. Public services Ombudsman schemes in Scotland, Wales and Northern Ireland have all been given statutory Complaint Standard Authority powers. Again, this demonstrates an unacceptable disparity between the rights of citizens in different parts of the UK.

[6] Venice Commission's opinion on PHSO's exclusion from the 'safe space'

In the absence of express statutory powers, PHSO has developed its own non-statutory Complaint Standards and we were impressed by the success of this and the very positive reception to this framework by Government and public bodies. However, PHSO's Complaint Standards do not have a statutory basis. This creates an inconsistent approach across the UK and it means that PHSO is out of line with other Ombudsman offices, as the devolved Ombudsman services have a reserve power to issue a notice of non-compliance if a public body does not fulfil the complaint standards required of it. This potentially weakens and undermines the PHSO's Complaint Standards. The solution is for a reformed English public services Ombudsman to have statutory Complaint Standards Authority powers.

Fifthly and lastly, our discussion of the Venice Principles naturally raises the wider issue of Ombudsman reform. This is not the place to rehearse all of the details of Ombudsman reform. Nonetheless, it is important to compare the position between the devolved nations and England/the UK. The devolved governments of Wales, Scotland and Northern Ireland have established their own integrated public service Ombudsman schemes. This provides a clarity to the public in terms of having a single public sector Ombudsman. By contrast, in England, complaints against central government and NHS bodies are considered by PHSO whereas complaints against local government and social care are considered by the Local Government and Social Care Ombudsman. There is also a range of other Ombudsman schemes.

The devolved public service Ombudsman schemes consider and investigate complaints about local government, health and devolved matters. People in Wales, Scotland and Northern Ireland must still complain to PHSO against those UK central government areas which have not been devolved. This raises the issue as to whether the Ombudsman service for residents in England should be reformed into a single public services Ombudsman and where exactly the consideration of complaints against non-devolved UK central government functions would sit. Having a single Public Service Ombudsman scheme for England and non-devolved UK matters would make it easier for members of the public to know where to turn.

PHSO's position is that its statutory framework is outdated, restrictive and out-of-step with both the frameworks of comparator international Ombudsman offices and the Venice Principles. PHSO has argued consistently for a single, readily identifiable public services Ombudsman in England to replace the current fragmented landscape. Important parts of PHSO's statutory framework need to be updated and revised. For instance, under the statute that created PHSO, the office is a corporation sole held personally by the office-holder who has a personal jurisdiction. The consequence of this is that she or he is personally accountable for the organisation. In practice, PHSO has appointed a Board to allow proper scrutiny, although there is no formal requirement for it to do so. This illustrates how PHSO has sought to accommodate the outdated nature of its statutory framework and how a complete revision and reform is required.

PHSO has also argued that there is a need for reform to remove the MP 'filter', introduce 'own initiative' powers and to give it Complaint Standards Authority powers thereby bringing the office into line with devolved UK ombudsman offices.

The UK Government has stated publicly that it will not take forward wholesale ombudsman reform until at least 2024. In the meantime, PHSO has continued to make its case and to work constructively with the Government to seek reforms, such as the removal of the 'MP Filter' for victims of crime who bring complaints to PHSO.

Given the above, the Panel concluded that there is an overwhelming case for a reformed public services Ombudsman. Such reform must protect the independence and autonomy of the Ombudsman, including its direct accountability to and relationship with Parliament, rather than Government. From the Government's perspective, we understand that reform is a question of not if but when. However, the 'when?' question has become increasingly urgent. It is now six years since the 2016 Bill was published and two years since the UK adopted the Venice Principles via the UN and Council of Europe. Further delay in achieving effective reform not only weakens the Ombudsman; it also disadvantages complainants and the public as a whole. For these reasons, we strongly recommend that the UK Government should progress with Ombudsman reform.

Date: 16 November 2022

Annex A: Comparison between the requirements of the Venice Principles and PHSO's current powers and operating models

Venice Principles	Assessment of whether PHSO's powers and operating model consistent with each principle
1. Ombudsman Institutions have an important role to play in strengthening democracy, the rule of law, good administration and the protection and promotion of human rights and fundamental freedoms. While there is no standardised model across Council of Europe Member States, the State shall support and protect the Ombudsman Institution and refrain from any action undermining its independence.	Fully consistent
2. The Ombudsman Institution, including its mandate, shall be based on a firm legal foundation, preferably at constitutional level, while its characteristics and functions may be further elaborated at the statutory level.	Partly consistent – limited by PHSO's legislation
3. The Ombudsman Institution shall be given an appropriately high rank, also reflected in the remuneration of the Ombudsman and in the retirement compensation.	Fully consistent
4. The choice of a single or plural Ombudsman model depends on the State organisation, its particularities and needs. The Ombudsman Institution may be organised at different levels and with different competences.	Not consistent – limited by PHSO's legislation
5. States shall adopt models that fully comply with these Principles, strengthen the institution and enhance the level of protection and promotion of human rights and fundamental freedoms in the country.	Partly consistent – limited by PHSO's legislation and operating model

6. The Ombudsman shall be elected or appointed according to procedures strengthening to the highest possible extent the authority, impartiality, independence and legitimacy of the Institution. The Ombudsman shall preferably be elected by Parliament by an appropriate qualified majority.	Mostly consistent – limited by Ombudsman recruitment conventions
7. The procedure for selection of candidates shall include a public call and be public, transparent, merit based, objective, and provided for by the law.	Fully consistent
8. The criteria for being appointed Ombudsman shall be sufficiently broad as to encourage a wide range of suitable candidates. The essential criteria are high moral character, integrity and appropriate professional expertise and experience, including in the field of human rights and fundamental freedoms.	Mostly consistent – limited by Ombudsman recruitment conventions
9. The Ombudsman shall not, during his or her term of office, engage in political, administrative or professional activities incompatible with his or her independence or impartiality. The Ombudsman and his or her staff shall be bound by self-regulatory codes of ethics.	Fully consistent
10. The term of office of the Ombudsman shall be longer than the mandate of the appointing body. The term of office shall preferably be limited to a single term, with no option for re-election; at any rate, the Ombudsman's mandate shall be renewable only once. The single term shall preferably not be stipulated below seven years.	Fully consistent
11. The Ombudsman shall be removed from office only according to an exhaustive list of clear and reasonable conditions established by law. These shall relate solely to the essential criteria of "incapacity" or "inability to perform the functions of office", "misbehaviour" or "misconduct", which shall be narrowly interpreted. The parliamentary majority required for removal – by Parliament itself or by a court on request of Parliament- shall be equal to, and preferably higher than, the one required for election. The procedure for removal shall be public, transparent and provided for by law.	Not consistent – limited by PHSO's legislation

12. The mandate of the Ombudsman shall cover prevention and correction of maladministration, and the protection and promotion of human rights and fundamental freedoms.	Partly consistent – limited by PHSO's legislation
13. The institutional competence of the Ombudsman shall cover public administration at all levels. The mandate of the Ombudsman shall cover all general interest and public services provided to the public, whether delivered by the State, by the municipalities, by State bodies or by private entities. The competence of the Ombudsman relating to the judiciary shall be confined to ensuring procedural efficiency and administrative functioning of that system.	Partly consistent – limited by PHSO's legislation
14. The Ombudsman shall not be given nor follow any instruction from any authorities.	Fully consistent
15. Any individual or legal person, including NGOs, shall have the right to free, unhindered and free of charge access to the Ombudsman, and to file a complaint.	Not consistent – limited by PHSO's legislation
16. The Ombudsman shall have discretionary power, on his or her own initiative or as a result of a complaint, to investigate cases with due regard to available administrative remedies. The Ombudsman shall be entitled to request the co-operation of any individuals or organisations who may be able to assist in his or her investigations. The Ombudsman shall have a legally enforceable right to unrestricted access to all relevant documents, databases and materials, including those which might otherwise be legally privileged or confidential. This includes the right to unhindered access to buildings, institutions and persons, including those deprived of their liberty. The Ombudsman shall have the power to interview or demand written explanations of officials and authorities and shall, furthermore, give particular attention and protection to whistle-blowers within the public sector.	Mostly consistent – limited by PHSO's legislation

17. The Ombudsman shall have the power to address individual recommendations to any bodies or institutions within the competence of the Institution. The Ombudsman shall have the legally enforceable right to demand that officials and authorities respond within a reasonable time set by the Ombudsman.	Fully consistent
18. In the framework of the monitoring of the implementation at the national level of ratified international instruments relating to human rights and fundamental freedoms and of the harmonisation of national legislation with these instruments, the Ombudsman shall have the power to present, in public, recommendations to Parliament or the Executive, including to amend legislation or to adopt new legislation.	Mostly consistent – limited by PHSO's operating model
19. Following an investigation, the Ombudsman shall preferably have the power to challenge the constitutionality of laws and regulations or general administrative acts. The Ombudsman shall preferably be entitled to intervene before relevant adjudicatory bodies and courts. The official filing of a request to the Ombudsman may have suspensive effect on time-limits to apply to the court, according to the law.	Fully consistent
20. The Ombudsman shall report to Parliament on the activities of the Institution at least once a year. In this report, the Ombudsman may inform Parliament on lack of compliance by the public administration. The Ombudsman shall also report on specific issues, as the Ombudsman sees appropriate. The Ombudsman's reports shall be made public. They shall be duly taken into account by the authorities. This applies also to reports to be given by the Ombudsman appointed by the Executive.	Fully consistent

21. Sufficient and independent budgetary resources shall be secured to the Ombudsman institution. The law shall provide that the budgetary allocation of funds to the Ombudsman institution must be adequate to the need to ensure full, independent and effective discharge of its responsibilities and functions. The Ombudsman shall be consulted and shall be asked to present a draft budget for the coming financial year. The adopted budget for the institution shall not be reduced during the financial year, unless the reduction generally applies to other State institutions. The independent financial audit of the Ombudsman's budget shall take into account only the legality of financial proceedings and not the choice of priorities in the execution of the mandate.	Fully consistent
22. The Ombudsman Institution shall have sufficient staff and appropriate structural flexibility. The Institution may include one or more deputies, appointed by the Ombudsman. The Ombudsman shall be able to recruit his or her staff.	Fully consistent
23. The Ombudsman, the deputies and the decision-making staff shall be immune from legal process in respect of activities and words, spoken or written, carried out in their official capacity for the Institution (functional immunity). Such functional immunity shall apply also after the Ombudsman, the deputies or the decision-making staff-member leave the Institution.	Fully consistent
24. States shall refrain from taking any action aiming at or resulting in the suppression of the Ombudsman Institution or in any hurdles to its effective functioning, and shall effectively protect it from any such threats.	Mostly consistent – limited by legislation

25. These principles shall be read, interpreted and used in order to consolidate and strengthen the Institution of the Ombudsman. Taking into consideration the various types, systems and legal status of Ombudsman Institutions and their staff members, states are encouraged to undertake all necessary actions including constitutional and legislative adjustments so as to provide proper conditions that strengthen and develop the Ombudsman Institutions and their capacity, independence and impartiality in the spirit and in line with the Venice Principles and thus ensure their proper, timely and effective implementation.	Partially consistent – limited by PHSO legislation

Annex B: List of documents reviewed

PHSO secretariat prepared a document review pack for the panel. This included the items noted below.

1. Strategy

1.1. Corporate Strategy 2022-2025

2. Annual reports

2.1. Annual Report and Accounts 2021-2022

2.2. Annual Report and Accounts 2020-2021

3. Finance and business planning

3.1. Business plan 2022-23

4. Peer review 2018

4.1. Value for Money Study

4.2. Overview of PHSO actions since last review (sent in supplementary papers)

5. PACAC

5.1. PACAC written submission (for year 2020-21)

5.2. PACAC report of annual scrutiny (for year 2020-21)

5.3. Response to PACAC scrutiny report (for year 2020-21)

5.4. Link to Rob Behrens' extension hearing

6. Governance and Risk

6.1. Governance Framework

6.2. Strategic Risk Register

6.3. Assurance framework

7. Transformation

7.1. Scope for each programme

8. External engagement

8.1. List of all 2021/22 publications

8.2. NHS Complaint Standards

8.3. UK Government Complaint Standards

8.4. Public Awareness – links to press stories over the last 6 months together with website statistics (sent in supplementary papers)

8.5. Public Awareness Surveys

9. Casework and Quality

9.1. Introduction to Service Model Guidance (sent in supplementary papers)

9.2. Outcome report of the Quality Programme

9.3. Quality Assurance Framework

9.4. Quality Standards and Measures

9.5. Introductory slides on Ombudsman Assurance

10. People

10.1. Organisational structure

10.2. Future Working Practices Report September 2022

10.3. Staff survey results 2021-22

10.4. Summary of engagement data (for years 2019-2021)

11. Venice Principles

11.1. Link to Venice Commission Opinion on safe space

12. A note from the Ombudsman in advance of the 2022 IOI-led peer review

12.1. Overview of Ombuds and Regulators (including budgets)

12.2. A summary of PHSO legislation

12.3. Confidential staff surveys (2016-2021)

12.4. Venice Principles paper for Peer Review panel

12.5. Venice Principles Benchmarking Analysis

12.6. Rob Behrens, *Reform of a national Ombudsman Scheme – A Journey*, in Stuhmcke and Groves, *The Ombudsman in the Modern State*, Hart Publishing, 2022

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