Memorandum to the Public Administration and Constitutional Affairs Committee by the Parliamentary and Health Service Ombudsman

Scrutiny inquiry 2018-19

24 April 2020

This memorandum summarises what we have achieved in 2018-19 and the latest available data from 2019-20. We have also appended some recent feedback from complainants, performance against our Service Charter, a summary of the latest staff survey results, a copy of the Venice Principles and the report of PHSO's review into the handling of Mr Nic Hart's complaint.

Summary

- During the past three years PHSO has been undertaking a significant transformation. We relocated most operational delivery from London to Manchester, restructured the organisation, reformed external engagement and recruited and trained around 100 new caseworkers.
- We launched a new three-year strategy in 2018 which set out PHSO's ambition to become an exemplary Ombudsman service. Since then, we have taken a number of important steps on our journey to realise this ambition, including major upgrades to desktop technology and casework systems. We have made these improvements at the same time as delivering a 24% budget reduction.
- Despite the significant scale and pace of the changes we have introduced, we have maintained casework productivity and performance in key areas, as well as service user satisfaction levels.
- We have restored links with the wider Ombudsman community internationally to share good practice and benchmark performance. In partnership with other European Ombudsman institutions we contributed to the development of an internationally recognised set of shared principles for good Ombudsman practice, known as the 'Venice Principles', to help uphold the independence and effectiveness of Ombudsman offices.
- We have seen a sustained increase in demand since early 2019. In the short-term this led to more cases waiting to be allocated to caseworkers, but we took steps to recruit and train more caseworkers and streamline processes to manage the increased demand effectively and reduce the queue. The Covid-19 national emergency has of course impacted on this.
- In 2020-21, we will be introducing further improvements to the organisation, including publishing most casework decisions online and introducing a new Complaints Standards Framework to be used across the NHS and, eventually, wider public services to improve the way complaints are handled.

- In response to the impact of the Covid-19 pandemic on frontline services, we have temporarily paused work on complaints about the NHS that require input from its workforce. We have also rapidly rolled out new technology to enable our staff to work from home. We are keeping the situation under constant review and will resume consideration of health complaints as soon as it is practical and reasonable to do so.
- The impact of Covid-19 is a significant disruption to our investigative work, but it may also affect the scale and pace of transformation and operational productivity in the weeks and months ahead.
- Looking beyond the next 12 months, our ambitions will be dependent on whether we receive the necessary investment from the next Comprehensive Spending Review. But we are clear that we could achieve an even greater impact for everyone who uses public services if Government brings forward legislation to establish a new Public Service Ombudsman, with responsibilities and powers in line with the established international good practice for Ombudsman services.

1. Introduction

1.1. Our vision

PHSO's vision is to be an exemplary public services Ombudsman by providing an independent, impartial and fair complaints resolution service, whilst using our casework to help raise standards and improve public services.

1.2. PHSO's role

We make final decisions on complaints that have not been resolved by the NHS in England and UK Government departments, and some other UK public organisations. We do this independently and impartially.

We are an independent national Ombudsman service. We are not part of Government, the NHS in England, or a regulator. We are neither a consumer champion nor an advocacy service, but we achieve justice for those who have suffered injustice or hardship as a result of failings in public services.

1.3. How we work

We look into complaints where an individual or group believes there has been injustice or hardship because an organisation has not acted properly or fairly, or has provided a poor service and not put things right.

When we first receive a complaint, we will make initial checks to see if we can deal with it. We may also work with a complainant and the organisation they are complaining about to see if we can help resolve issues at this early stage.

If a complaint moves past this stage, then we take a closer look to decide how best to resolve matters. We may decide to investigate, or we may be able to achieve a resolution without needing to pursue an investigation.

If we decide to investigate, we will gather information from the complainant and the organisation they are complaining about before we make our final

decision about the complaint. When we uphold a complaint, we can recommend what the organisation should do to put things right.

1.4. Data about PHSO's performance

This memorandum includes data about PHSO's performance. We have provided the latest data available at the time of writing. This means that, where possible, we have provided data from 2018-19 as well as the latest available data from 2019-20.

At the end of each financial year, we carry out checks on performance data to make sure it is accurate before we publish it in PHSO's annual report. As a result, the data that appears in the forthcoming 2019-20 annual report may differ slightly from 2019-20 data provided in this memorandum.

2. Strengthening the organisation

2.1. Improving casework

We have continued to build on the wide-ranging improvements we have been making to our casework processes since 2017. This includes a new framework for checking and improving the quality of casework. We are now systematically assessing casework against the measures that matter most to complainants and organisations we investigate, such as communicating well, explaining decisions clearly, and demonstrating both empathy and impartiality.

As well as strengthening the quality of casework, we are also looking for more opportunities to resolve complaints at an earlier stage in the process. This allows us to achieve the right decision at the right time, tailored to each individual complaint, without always needing to put complainants or organisations through the more time-consuming process of an investigation over many weeks or months.

There are a number of ways we can do this, including through Early Dispute Resolution, which we are currently piloting. We are also doing more to identify cases where something has gone wrong but there are no signs that someone suffered injustice as a result, or where there are no signs that anything has gone wrong. We can work with the complaint and the organisation to close these cases without the need for an investigation.

By focusing increasingly on how we can achieve a resolution earlier, we are also providing better value for money for the taxpayer. We look at each complaint carefully to identify which ones could be resolved earlier on in our process and which ones might only be resolved through an investigation. Overall, this means we are closing more cases earlier on in the process. Independently gathered feedback from complainants has remained consistent as we embed this model.

In 2018, we commissioned an independent review of the way we use advice from expert clinicians in the complaints we receive about the NHS in England. The review was chaired by Sir Alex Allan KCB, who is a non-executive member of PHSO's board. The former Chief Medical Officer, Sir Liam Donaldson, was appointed as the independent adviser to the review.

In the review's final report in spring 2019, there were several recommendations about how to strengthen our approach to clinical advice. We are currently implementing the review's recommendations. These range from sharing clinical advice with complainants and the organisations we investigate, to holding multidisciplinary meetings where colleagues with expertise in different fields come together to discuss complex cases. In 2019 we published new information to help complainants understand the role of clinical advice from the outset of an investigation. We are also in the process of publishing new guidance about how we balance evidence when we make decisions about a case.

In preparation for publishing most casework decisions by March 2021, we have begun to roll-out significant changes to help make sure the reports we produce are written and presented in a consistent, clear and accessible way, without publishing personal information about complainants or their loved ones.

We are also delivering a sector-leading accreditation programme for senior caseworkers. By April 2020 most senior caseworkers will have completed the accreditation process. This qualifies them to work with greater autonomy.

In future, we aim to develop the accreditation programme into externally recognised qualifications at different levels. We then aim to be able to offer access to these qualifications to other Ombudsman staff and to complaint-handlers across the administrative justice sector, to help establish clearer career pathways and to create an embryonic complaints-handling profession. This ambition will only be fully recognised if we can secure investment in the next Comprehensive Spending Review.

In 2019, we carried out a review of PHSO's handling of a complaint made by Mr Nic Hart following the tragic death of his daughter Averil. This review was carried out so that we could learn from failings in our investigatory process and account for that learning publicly.[1]

The review found failings ranging from the length of time it took to conclude the case, to failings in the way PHSO communicated with Mr Hart. We have apologised unreservedly for the difficulties and stress these caused Mr Hart and his family at an already distressing time when they were grieving for their loved one.

The review also found that PHSO has taken steps to learn from each of its failings since the case was concluded in 2017. Independent Expert Advisory Panel Member, James Titcombe, described the review as a "candid account" of PHSO's failings and acknowledged that "it's crucial that organisations are able to reflect candidly when they get things wrong and this review is a welcome example of that".[2]

The full report of the review is enclosed as an appendix to this memorandum and it has been published on PHSO's website.

[1] The full report of the review is published on PHSO's website: https://www.ombudsman.org.uk/publications/report-review-phsos-handling-mr-nic-harts-case-august-2014-december-2017

[2] https://www.ombudsman.org.uk/news-and-blog/blog/learning-mistakes-open-and-honest-review-failings-handling-serious-complaint

2.2. Strengthening the organisation

As part of the 2015 Comprehensive Spending Review, PHSO committed to reducing its costs by 24%. We have successfully delivered this commitment, having achieved over £6.5million in savings between 2016-17 and 2018-19. As we highlighted to the Committee last year, making these savings has required major and rapid change.

Alongside reducing costs, we have continued to transform the organisation while delivering the objectives of our strategy. As a result, we are a leaner organisation, but with reduced flexibility to meet unexpected pressures. This means we are only able to respond to increased demand for our service by improving productivity or recruiting more caseworkers, and this inevitably takes time.

We have made extensive improvements to ICT, replacing several outdated legacy systems, software and services within a short timeframe including all ICT infrastructure and support capability. During 2019-20, we also replaced the main system for managing casework. Each of these improvements were successfully delivered in parallel and at the same time as responding to increased demand.

In 2018-19, PHSO's staff received 2,315 days of training. This included ongoing professional training for caseworkers to improve their skills and expertise, as well as a new programme to support managers to lead and develop their teams. More recently, we have started a new training programme to equip casework teams with enhanced report-writing skills in preparation for publishing casework decisions from March 2021.

We have established a new Expert Advisory Panel comprised of four independents experts who support and challenge us to continually improve the organisation and our service. Members of the panel were selected by fair and open competition and bring expertise in patient safety, dispute resolution, investigations, and learning from failings in NHS services.

Last year we agreed with the Committee's recommendation to strengthen our understanding of whether people who use PHSO's service feel we are impartial. We commissioned an independent research agency to run focus groups on this topic as well as 25 in-depth interviews with individual complainants. Analysis of their findings is still ongoing, and we will consider carefully how to use the learning from this research to improve people's experience of the service we provide.

3. Performance and impact

3.1. Operational performance

We received over 112,000 enquiries and complaints in 2018-19. This included handling nearly 30,000 complaints and providing advice and signposting for nearly 83,000 enquiries.

Despite the significant changes made to the organisation and delivering the last year of CSR savings, we have successfully maintained and improved operational productivity. We are closing enquiries and complaints more quickly. In 2018-19 it took us an average of 158 days to close a case. From April

to December 2019-20, we closed cases in an average of 140.8 days. 50.3% of cases were closed within 13 weeks and 79.7% were closed within 26 weeks[3].

This performance has also come at a time when we have seen a 13% increase in demand for our service. This increase has been sustained since early 2019. There is no single underlying reason for this increased demand and other Ombudsman services including the Local Government and Social Care Ombudsman are experiencing a similar increase.

We had to reduce staff numbers as part of the savings we needed to make following the 2015 Comprehensive Spending Review. In turn, this reduced flexibility to respond to unexpected and prolonged increases in demand.

The sustained increase in demand means that more people are now waiting for their case to be allocated to a caseworker. To manage this, we made a successful bid to the Treasury for extra funds and have recruited additional caseworkers. We have also provided more training and support to improve the productivity of existing casework teams even further. These steps will reduce the size of the queue over time, but it will take several months for them to have an impact. It takes around six months to fully train and induct new caseworkers and this is now being impacted by the arrangements we have had to put in place to deal with the restrictions imposed by Covid-19.

The impact of the Covid-19 pandemic has had broader consequences on our casework as well of course. We have temporarily paused consideration of most complaints about the NHS in response to the crisis. In these difficult and unprecedented times, we do not want to add any further pressure into the system or risk diverting precious NHS resource away from dealing with the pandemic. This includes complaints teams who have been moved temporarily to other, pandemic-related roles. We will continue to progress health cases up to the point we need to contact an NHS organisation or get clinical advice.

Our phone lines remain open to the public and we continue to accept and progress complaints about Government departments and other public bodies where we are able to do so. We also continue to provide advice about the complaints process and signpost people to organisations that can help. We consider this an important public service.

We will resume consideration of complaints about the NHS as soon as practically possible. We will keep the situation under close, weekly review. This means we will have outstanding work to progress once we restart work on complaints. We are carefully considering and scenario planning for what the impact of this will be.

3.2. Managing the organisation

As we have previously highlighted to the Committee, since 2017 PHSO has seen a significant amount of change. This has been sustained throughout 2018-19 and 2019-20, and will continue over the coming year too on our journey to becoming an exemplary Ombudsman service.

We have involved colleagues across the organisation throughout the transformation. PHSO's 2018-19 staff survey results demonstrated an overwhelming improvement in many areas. There was a 64% increase in the

[3] Data correct as of the end of January 2020.

proportion of staff who said the Ombudsman and CEO have a clear vision for the future of PHSO and a 34% increase in the proportion who felt valued for the work they do. The overall engagement score was 67%, which is a 15% increase since 2016.

These high scores were largely sustained in the most recent staff survey from October 2019. The overall engagement score of staff remains slightly above the average for civil service organisations. The results are enclosed as an appendix to this memorandum.

In 2019-20, we introduced a new pay and grading framework for our staff. The previous approach was complex and lacked transparency, including 150 different pay points and with people in the same role paid at significantly different rates. The new framework provides a much simpler and more transparent approach by streamlining pay rates into seven pay grades. We designed the new approach after listening to feedback from staff and trade unions, but we were unable to reach an agreed position before the survey took place. Frustration with this is reflected in some of the survey scores.

3.3. Improving public services

We have continued to highlight the learning from the complaints we receive to support improvements to public services for everyone. As well as publishing regular case studies of complaints that highlight the importance of learning from mistakes, we have also shone a spotlight on more systemic issues.

In December 2018, we published the first of two investigations into failings by the Care Quality Commission (CQC) in examining how NHS organisations apply the 'fit and proper person test'. This test is intended to assure that executive and non-executive directors are suitable and fit to undertake the responsibilities of their role in the NHS.

Since then, we have also published *Missed Opportunities*, a report looking at failings in the care and treatment of two young men who died shortly after being admitted to the former North Essex Partnership NHS Trust. We found that lessons were not learnt following serious incidents and risks to patients' safety were not addressed over a period of several years. As a result of our report, NHS England and NHS Improvement have committed to carrying out a review into what happened at the Trust to help make sure the learning from these failings inform improvements in patient safety elsewhere. We also published the report of an investigation into the complaint made by Ms Leahy, whose son tragically died following failings at North Essex Partnership NHS Trust.

Most recently, we have published the first Annual Ombudsman's Casework Report. This is a summary of complaints we closed in 2019 that demonstrate the value and importance of complaining, not only in achieving justice for individuals, but also in improving public services.

In 2018 we started publishing quarterly reports to share information and themes from the complaints we have received about the NHS in England. We expanded these reports in 2019-20 to include case studies of resolved complaints as well as information about the recommendations we have made to the organisations we investigate.

In 2018-19 we made 1,408 recommendations to encourage learning and improvement in the organisations we investigate. This included recommendations that organisations make £252,473.18 worth of payments to complainants for financial loss or to recognise the impact of what went wrong. In 2019-20 we recommended financial remedies totalling £349,010.53 so far.[4] In addition to this, we closed two cases relating to NHS-funded social care, which led to six-figure sums of financial remedy being awarded to the complainants. One of these cases was successfully closed by working with the complainant and the organisation complained about to agree a resolution without the need for an investigation.

Since 2018 we have led a significant programme of work in partnership with a wide coalition of organisations including NHS and social care regulators and advocacy groups. This partnership is working to develop a single, shared set of standards for good practice in complaint-handling, known as the Complaints Standards Framework, which we will be launching later this year for public consultation. This follows feedback from frontline complaint-handlers that there is no shared view of what good complaint-handling looks like.

The extent of our ability to support public services to improve the quality of their complaint-handling will depend on much-needed investment from the forthcoming Comprehensive Spending Review.

In partnership with European Ombudsman institutions, we contributed to the development of an internationally recognised set of shared principles for good Ombudsman practice by the European Commission for Democracy Through Law.[5] These 'Venice Principles' are key benchmarks to help uphold the independence and effectiveness of Ombudsman offices throughout Europe. We would welcome these principles being adopted by the United Nations in a similar way to how the Paris Principles were adopted for international Human Rights institutions. We have recently submitted our views on this to the UN as part of a consultation it has run on Ombudsman matters. The Venice Principles are appended in full.

In September 2019 we co-hosted an event in Parliament with the International Ombudsman Institute, the main membership body for national Ombudsman services around the world, to share good practice. This event focused on systemising the learning from the independent peer review of PHSO's value-for-money, which we commissioned in 2018 on PACAC's recommendation. PHSO is now seen as leading the sector in this field, and the Ombudsman has shared the experience in North America and western Europe.

3.4. Engaging externally

We visited more than 80 organisations in 2018-19 and a further 51 in 2019-20 as part of our aim to better our understanding of bodies in jurisdiction, strengthen relationships with external partners and increase our visibility in sharing best practice with frontline complaints handlers.

[4] There are seven cases where the value of the financial remedy has not yet been determined. This is because we asked the organisations investigated in these cases to complete work to determine the value of the payments to be made and this work is currently ongoing.
[5] The Venice Principles are published in full on the Council of Europe's website: https://www.venice.coe.int/files/Publications/Venice_Principles_eng.pdf

Many of our visits were to NHS Trusts, where we spoke to a wide range of people including complainants, clinical and non-clinical staff, managers and board members. This enabled us to understand better organisational culture, the pressures on Trusts, and how learning from complaints can make a positive difference to improving services for the benefit of both patients and staff.

Feedback on our visits and seminars remains very positive, with many frontline complaints-handlers valuing the opportunity to discuss the complex issues involved in responding to complaints effectively. This allows us to help shape best practice in complaints-handling as we share knowledge and learning.

PHSO now provides the secretariat for the Public Service Ombudsman Group, an affiliate of the Ombudsman Association, consisting of PHSO, Ombudsman services from the devolved nations, the Local Government and Social Care Ombudsman, the Housing Ombudsman and the Ombudsman institutions of Ireland, Gibraltar and Malta. This group has been central throughout the period under review in liaising on Ombudsman issues related to Brexit and keeping lines open to the European Ombudsman in Brussels.

More than 200 people attended our second annual Open Meeting in June 2018, and we continued this series of events with the latest Open Meeting in June 2019. Speakers included Rosemary Agnew, Scottish Public Services Ombudsman, Peter Tyndall, Ombudsman for Ireland and President of the International Ombudsman Institute, and Jonathan Slater, Permanent Secretary at the Department for Education. Attendees included people who have recently used our services, organisations we investigate, and representatives from other national bodies we work with.

We have also continued to build on the Radio Ombudsman podcast series, which has reached over 5,000 listeners since it was launched in 2017. Guests featured on the podcast have included Rebecca Hilsenrath, CEO of the Equality and Human Rights Commission, Rachel Power, CEO of the Patients Association, and patient safety campaigner and expert by experience, Scott Morrish.

4. Improving impact

4.1. Plans for the year ahead

We are now two years into our three-year strategy. We have made a number of significant steps towards our ambition to become an exemplary Ombudsman service, but there is more for us to do to continue to improve our casework, organisation and profile. There are also now some unknowns and challenges that will affect the scale and pace of transformation and operational productivity over the next period.

As we prepare for casework decisions to be published from March 2021 onwards, we will need to make further changes to casework processes to protect complainants' privacy and personal information and ensure reports are accessible for a wider audience. We will also need to make some additional changes to our technology and systems.

We will continue to monitor the impact of the Covid-19 pandemic on PHSO, complainants, the NHS and other public services. We will use the complaints we receive to support public services with learning as they start to move beyond the immediate crisis later in the year.

The next year will also be a crucial turning point for the work we are doing to help NHS and other public services to respond effectively to complaints. We will work with our partners to embed the forthcoming Complaints Standards Framework in policy and practice. We are also working with Government departments to explore how a similar model could be adopted by these bodies.

Over the coming year we will also develop PHSO's next corporate strategy, which will set out our ambitions for 2021-24. We will consult on our approach and would welcome views from Committee members on the ambitions set out in the draft document.

4.2. Ombudsman reform is essential to increase access to justice

PHSO's casework helps individuals and groups who use public services to achieve justice and resolution when things go wrong. The learning from this casework also helps public services to improve for everyone. Through our relationship with PACAC, we also support Parliament to scrutinise Government and hold it to account.

We would be able to achieve an even greater impact if the outdated legislation that underpins our work was reformed. As the independent review of PHSO's value-for-money found, "PHSO is now out of line with other UK public services Ombudsman offices and wider international practice".[6] Reforming the Ombudsman would enable "more effective access to justice for all citizens and seek to improve public service delivery".[7]

Both PHSO and the Local Government and Social Care Ombudsman want to see our two Ombudsman services replaced with a single Public Service Ombudsman, with an integrated jurisdiction across health, social care, local government, UK Government departments and other public services. This would make the complaints process easier for complainants and organisations we investigate, and provide better value-for-money for the taxpayer. While any new Public Service Ombudsman would need to be supported with initial investment, we would expect it to be more efficient in the longer-term.

We are also increasingly out of step with international standards of good practice in Ombudsman services and lagging behind other ombudsman services in the UK. Unlike Ombudsman institutions in Wales and Northern Ireland, PHSO does not have the power of 'own initiative' to look at the injustice or hardship faced by people who are unable or unwilling to complain. This leaves people who are in vulnerable circumstances without the opportunity to achieve justice when they have been let down by the public services they should be able to rely on.

While we are working closely with other national bodies and the organisations we investigate to help improve the quality of complaints-handling in public services, our ability to influence this improvement is limited by our powers. Unlike the Scottish Public Service Ombudsman, we do not have the power of a

[6] Tyndall, P., Mitchell, C., Gill, C. *Value for Money Study: Report of the independent peer view of the Parliamentary and Health Service Ombudsman*. 2018: https://www.ombudsman.org.uk/news-and-blog/blog/our-value-money-independent-review.
[7] Tyndall, P., Mitchell, C., Gill, C. *Value for Money Study: Report of the independent peer view of the Parliamentary and Health Service Ombudsman*. 2018: https://www.ombudsman.org.uk/news-and-blog/blog/our-value-money-independent-review.

‘Complaints Standards Authority’ to set the standards for complaints-handling. Such powers would add greater authority to the complaints standards we are developing and allow us to take action where public services are not meeting those standards.

Members of the public can bring a complaint about a UK Government department or agency to us only if their complaint has been referred to us by their local MP. This arrangement dates from 1967, when the Ombudsman was first established. MPs play a vital role in supporting constituents to resolve their concerns, but the outdated ‘MP filter’ creates an additional hurdle for complainants in bringing their complaint to us.

Any reform of legislation would also need to consider how best Parliament can hold the Ombudsman service to account, and use the learning from its casework to hold Government and other public services to account.

The Government published the Draft Public Service Ombudsman Bill to modernise the Ombudsman service more than three years ago. As yet this legislation has not been introduced to parliament. Over the past three years, the Ombudsman sector has continued to develop. The draft bill is no longer aligned with internationally recognised good practice as set out in the Venice Principles which are enclosed in the appendix. The Government’s plans for Ombudsman reform now need to be revisited to keep pace with established good practice and ensure that a new Public Service Ombudsman is fit for purpose to achieve a greater impact for more people, more easily and more efficiently.

As an impartial and independent public service Ombudsman, PHSO plays a vital and unique role. Through resolving complaints and providing advice and signposting, PHSO helps thousands of people every year, as well supporting public services to learn and improve for everyone’s benefit. Modernising and integrating the Ombudsman service would strengthen its impact and yield benefits for Parliament, public services, and the wider public.

Appendices:

a. Recent feedback from complainants
b. PHSO’s performance against the Service Charter
c. Staff survey results 2019
d. Report of a review into the Parliamentary and Health Service Ombudsman’s handling of Mr Nic Hart’s case from August 2014 to December 2017
e. Principles on the protection and promotion of the Ombudsman institution (‘The Venice Principles’)

Appendix A: Recent feedback from complainants

This appendix includes examples of recent feedback from complainants who had different outcomes from the complaints they brought to us. This includes people whose complaints were upheld, partly upheld or not upheld following an investigation, through to those whose cases we closed earlier in our process without an investigation.

"You're worth your weight in gold… you're wonderful"

"I wish to thank you for your diligence and hard work in completing the investigation into our complaint"

"May I express my sincere thanks to you… You provided a service to me that was second to none and I am very happy with the hard work you have done on my behalf"

"Thank you again for all help and fantastic service"

"I would like to thank you and [name removed] for all your hard work and persistent work in getting to the bottom of what actually happened… Without your intervention we would never have obtained the truth"

"Many thanks for being so understanding with what is a very difficult situation"

"Thank you for your comprehensive letter outlining your provisional report. Whilst I'm disappointed that the issue [I complained about] will not be addressed, I understand the points you have raised"

We have included positive feedback here to illustrate the ways in which many complainants have a good experience when they use PHSO's service, recognising that the Committee receives direct feedback from complainants who are unhappy about their experience.

Appendix B: PHSO's performance against the Service Charter

PHSO's Service Charter[8] makes commitments about the service PHSO provides throughout the different stages of our process. We use these commitments to measure how well we are delivering our service and understand where we need to improve.

We developed the Service Charter with people who have used PHSO's service and the organisations we investigate and work with, to find out what matters to them. We publish Service Charter scores on a quarterly basis.

We collect and publish feedback from complainants to provide a better view of our service from those who use it. In the second half of 2018-19 we piloted collecting feedback from organisations we investigate as well, and we rolled this out in full from the start of 2019-20, as the table below shows.

We use an independent research agency to collect and collate feedback from complainants and organisations we investigate. We are currently the only public service Ombudsman that carries out regular surveys of this nature.[9]

	Commitment	2018/19 score – Complainant Feedback	2019/20 year-to-date score[10] - Complainant Feedback	2019/20 year-to-date score[11] - Organisations we Investigate Feedback
Giving you the information you need				
1	We will explain our role and what we can and cannot do	79%	78%	85%
2	We will explain how we handle complaints and what information we need from you	80%	80%	82%

[8] PHSO's Service Charter is published in full on our website: https://www.ombudsman.org.uk/making-complaint/how-we-deal-complaints/our-service-charter
[9] This means there is no standard benchmark against which to compare the results of our Service Charter surveys.
[10] Results from July to September 2019.
[11] Results from July to September 2019.

3	We will direct you to someone who can help with your complaint if we are unable to, where possible	78%	75%	N/A
4	We will keep you regularly update on our progress with your complaint	81%	81%	89%
Overall performance **Target for complainant feedback: 75%**[12]		**79%**	**79%**	**85%**
Following an open and fair process				
5	We will listen to you to make sure we understand your complaint	73%	69%	84%
6	We will explain the specific concerns we will be looking into	88%	89%	88%
7	We will explain how we will do our work	77%	86%	90%
8	We will gather all the information we need, including from you and the organisation you have complained about before we make our decision	48%	48%	88%
9	We will share facts with you, and discuss with you what we are seeing	68%	73%	85%
10	We will evaluate the information we have gathered and make an impartial decision on your complaint[13]	-	-	-
11	We will explain our decision and recommendations, and how we reached them	53%	47%	90%

[12] Targets will be set for feedback from organisations we investigate once we have collected sufficient data over a period of time to establish a baseline.
[13] Last year we agreed with the Committee's recommendation to strengthen our understanding of whether people who use PHSO's service feel we are impartial. We commissioned an independent research agency to run focus groups on this topic as well as 25 in-depth interviews with individual complainants. Analysis of their findings is still ongoing and we will consider carefully how to use the learning from this research to improve people's experience of the service we provide.

Overall performance **Target for complainant feedback: 65%**[14]		**68%**	**69%**	**88%**
Giving you a good service				
12	We will treat you with courtesy and respect	90%	87%	92%
13	We will give you a final decision on your complaint as soon as we can	53%	51%	77%
14	We will make sure our service is easily accessible to you and give you support and help if you need it	67%	66%	90%
Overall performance **Target for complainant feedback: 70%**[15]		**70%**	**68%**	**86%**

[14] Targets will be set for feedback from organisations we investigate once we have collected sufficient data over a period of time to establish a baseline.
[15] Targets will be set for feedback from organisations we investigate once we have collected sufficient data over a period of time to establish a baseline.

Appendix C: Staff survey results 2019