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Public Administration
and Constitutional Affairs
Committee

**PHSO Annual Scrutiny
2016–17**

Third Report of Session 2017–19

*Report, together with formal minutes relating
to the report*

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Public Administration and Constitutional Affairs

The Public Administration and Constitutional Affairs Committee is appointed by the House of Commons to examine the reports of the Parliamentary Commissioner for Administration and the Health Service Commissioner for England, which are laid before this House, and matters in connection therewith; to consider matters relating to the quality and standards of administration provided by civil service departments, and other matters relating to the civil service; and to consider constitutional affairs.

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The current staff of the Committee are Dr Rebecca Davies (Clerk), Libby Kuriem (Clerk), Ian Bradshaw (Second Clerk), Dr Patrick Thomas (Committee Specialist), Dr Philip Larkin (Committee Specialist), Makka Habre (Committee Specialist), Henry Midgley (Committee Specialist), Gabrielle Hill (Senior Committee Assistant), Iwona Hankin (Committee Assistant), and Mr Alex Paterson (Media Officer).

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Contents

Summary	3
1 Introduction	4
2 Future strategy	5
The challenge	5
The Ombudsman’s draft strategic plan	5
Future Public Service Ombudsman	8
Staff engagement	8
3 PHSO’s performance in handling complaints	10
Timeliness of decisions	10
Learning from mistakes	11
Correcting mistakes	11
PHSO’s service charter	12
Impartiality and unconscious bias	13
Data protection	14
4 Historic complaints	16
5 Improving public services	18
Implementation of recommendations	18
Improving local complaint handling	18
Conclusions and recommendations	20
Formal minutes	24
Witnesses	25
Published written evidence	25
List of Reports from the Committee during the current Parliament	27

Summary

The Parliamentary and Health Service Ombudsman (PHSO) is the complaint handler of last resort for individuals who have complaints about public services provided by UK Government Departments and the NHS in England. The Ombudsman is independent of the Government, and is accountable to Parliament through the Public Administration and Constitutional Affairs Committee.

The PHSO is in the middle of a period of significant change. The current Ombudsman, Rob Behrens, took up his role in April 2017 following the resignation of his predecessor. The organisation is required to make a 24% real terms reduction in its spending over the next two years. The PHSO needs mechanisms that provide robust external assurance of its value for money and its impact on improving public services, especially if it wants to argue for increased funding in the future.

The PHSO's performance in handling complaints has been repeatedly criticised in recent years. The time taken to complete investigations has improved but was described to us as simply unacceptable by its Chief Executive Amanda Campbell. Mr Behrens has made restoring public trust in the Ombudsman one of his priorities. We welcome the introduction of the PHSO's new service charter, which includes systematic monitoring of complainants' views, and its new strategic plan. We will hold the Ombudsman to account for delivering the latter.

The legislation underpinning the PHSO is over fifty years old, and prevents it adopting modern corporate governance arrangements. The Government published draft legislation in 2016 that would merge PHSO with the Local Government and Social Care Ombudsman, and modernise its governance. We conclude that the Government should provide clarity about whether it intends to introduce the legislation, and on what timetable, to allow the PHSO to plan effectively.

Eighty-eight per cent of the PHSO's casework in 2016–17 related to the NHS. The capacity of local complaint handling in the NHS therefore has a substantial impact on the PHSO, as well as on the individual complainants. NHS complaints handling has been the subject of repeated criticism by ourselves and the Health Committee. PHSO has committed to sharing its best practice and developing training for local complaints handlers. However, substantive change will need leadership from the NHS and Department of Health and Social Care. The establishment of the Health Safety Investigation Branch, on the recommendation of our predecessor Committee, is a necessary but not sufficient step to achieve this. It is vital that the draft Health Services Safety Investigation Bill, which will provide statutory underpinning for the new system' receives pre-legislative scrutiny at the earliest opportunity so momentum is maintained.

There are also a small number of 'historic cases' relating to the NHS where it appears injustice remains but that it would not be appropriate for the PHSO to investigate, or in some cases re-investigate. The Government should instead develop a proportionate, time limited, mechanism to independently investigate and address those cases where legitimate questions or grievances remain.

1 Introduction

1. The Parliamentary and Health Service Ombudsman (the Ombudsman) combines the statutory roles of Parliamentary Commissioner for Administration and Health Service Commissioner for England.¹ As such the Ombudsman adjudicates on complaints that have not been resolved by the NHS in England and UK Government Departments. The post is currently held by Rob Behrens. There are separate ombudsman arrangements for local government services in England and for public services provided by the devolved governments.

2. The Ombudsman is supported by an organisation with approximately 475 staff and an annual budget of approximately £35m, also known as the Parliamentary and Health Service Ombudsman.² For clarity, in this report we refer to Mr Behrens as “the Ombudsman” and the organisation he leads as the PHSO. Amanda Campbell is the Chief Executive of the PHSO.

3. The Ombudsman has discretion to choose which complaints he investigates. In 2016–17 he received 31,444 new complaints, of which he assessed 8,119 as being cases he could investigate.³ PHSO completed investigations into 3,767 cases in 2016–17.⁴

4. The Ombudsman is independent of the Government, the NHS and Parliament. He is accountable to Parliament, through the Public Administration and Constitutional Affairs Committee (PACAC), for the overall performance of the PHSO and for its use of resources.⁵ This has traditionally been through an annual evidence session based on the PHSO annual report and accounts. The Committee does not inquire into individual cases. However, the Ombudsman can lay reports before Parliament, often to highlight cases that he feels raise issues of wider concern. One such report was *Ignoring the Alarms: How NHS eating disorder services are failing patients*, laid before Parliament on 8 December 2017.⁶

5. Mr Behrens took up the role of Ombudsman in April 2017 following a joint pre-appointment hearing with PACAC and the Health Select Committee.⁷ He replaced Dame Julie Mellor who resigned in July 2016, because of the criticism of her handling of the appointment of the deputy Ombudsman, but stayed in post until her successor was appointed.⁸

6. The Committee held its annual scrutiny session with the Ombudsman and Amanda Campbell on 12 December 2017. It focussed on the PHSO’s annual report for 2016–17, the final year of Dame Julie Mellor’s period in office, and the new strategic plan for the period 2018 to 2021 published for consultation by Mr Behrens in November 2017. Prior to the evidence session, the Committee accepted 38 written submissions from individuals and organisations relating to their experience of the PHSO as complainants. The Committee is thankful to all those who submitted evidence.

1 Parliamentary and Health Service Ombudsman, “[Who we are](#)” accessed 09 February 2018.

2 Parliamentary and Health Service Ombudsman, “[The Ombudsman’s Annual Report and Accounts](#)”, HC207, 18 July 2017, p 60 & 67

3 *ibid* pp 6–12

4 *ibid*

5 House of Commons “[Standing Orders \(Public Business\)](#)” HC 4, April 2017, Standing Order 146

6 PHSO “[Ignoring the Alarms: How NHS eating disorder services are failing patients](#),” HC 634, 8 December 2017. Further examples include “[Driven to Despair: How driver have been let down by the Driver and Vehicle Licensing Agency](#)”, HC 660, 19 October 2016; and “[A report of investigations into unsafe discharge from hospital](#)”, May 2016.

7 Health and Public Administration and Constitutional Affairs Committees, fifth report of the Health Committee and eighth report of the Public Administration and Constitutional Affairs Committee of Session 2016–17 “[Appointment of the Parliamentary and Health Service Ombudsman](#)”, HC 810, 19 January 2017.

8 Alex Alan “[Report of a Review into Issues Concerning the PHSO](#)” 13 September 2016

2 Future strategy

The challenge

7. Mr Behrens defined the challenge the PHSO faces in a public lecture on 7 December 2017 as:

The Parliamentary and Health Service Ombudsman (PHSO) needs transformation, and indeed, irrespective of legislative change it is being transformed to become a more outward-facing, transparent organisation, closer to the communities it serves, without surrendering an iota of its independence. A key challenge is to restore user and stakeholder trust and this will not be easy.⁹

8. The loss of stakeholder trust is clear from the reports produced by the Patients' Association between 2014 and 2016, entitled respectively, *PHSO - The People's Ombudsman - How it failed us* (November 2014); and *PHSO - Labyrinth of Bureaucracy* (March 2015) as well as their later *Follow up Report* (December 2016).¹⁰ In evidence to the Committee in January 2016, based on calls to their helpline, the Association described, "the heavy toll" it felt the PHSO investigation process put on complainants and that families were left "distressed, exhausted and distraught by the failings of the body to carry out their public function in an efficient, effective and caring manner."¹¹

9. The PHSO has faced more than a loss of trust from complainants. As described below its performance in delivering timely decisions has been, in its own judgement, "simply unacceptable".¹² The last Ombudsman and her deputy resigned in 2016 as a result of serious governance failings in the appointment of the Deputy Ombudsman.¹³ In 2014–15 the PHSO's annual accounts were qualified by the National Audit Office owing to failings in its financial monitoring.¹⁴ The 2015–16 accounts were published late to allow further assurance work to be carried out, and highlighted concerns about a failure to implement internal audit recommendations.¹⁵

The Ombudsman's draft strategic plan

10. Against this context the new Ombudsman published a draft strategic plan for consultation on 6 November 2017 to cover the three years from April 2018 to March 2021.¹⁶ It set out three objectives and the change that will underpin them. The objectives are:

- **Objective 1:** To deliver an independent, impartial and fair Ombudsman service.
- **Objective 2:** To increase the transparency and impact of our casework.
- **Objective 3:** Working in partnership to improve front-line complaints handling and public services.¹⁷

9 Rob Behrens, "Looking Back to Look Forward: Celebrating 50 years of the Parliamentary and Health Service Ombudsman and a glimpse into the future", LSE Annual Ombudsman's Lecture, 4 December 2017

10 Summarised in Karen Murphy, Chief Executive of the Patients' Association, evidence to the Committee's annual scrutiny of PHSO in Jan 2016 (PAR 47) and The Patients Association, "[Follow-up report to the March 2015 Patients Association publication on the Parliamentary and Health Service Ombudsman](#)", December 2016.

11 PAR 47

12 Q37

13 Alex Alan "[Report of a Review into Issues Concerning the PHSO](#)" 13 September 2016

14 Parliamentary and Health Service Ombudsman "[The Ombudsman's Annual Report and Accounts 2014–15](#)" HC (2015–16) 570, 9 November 2015, pp 93–94

15 PACAC Oral Evidence "[Public and Health Service Ombudsman Annual Scrutiny 2016](#)" HC 809 2016–17, Q 18–24

16 Rob Behrens, "[Shaping the Future: Let us know what you think of our new strategy](#)" 6 November 2017

17 PHS 49, Annex

11. The final version of the strategy, published on 16 April 2018, amended Objective 1 to “improve the quality of our service, while remaining independent, impartial and fair” and Objective 3 to “work in partnership to improve public services, especially frontline complaint handling”.¹⁸

12. Mr Behrens described the draft plan as “modest” and “realistic”, and would allow the Committee to measure the PHSO’s progress “year by year”.¹⁹ This contrasted with the PHSO’s past tendency to, “make statements about what it is going to do without having them properly supported, both in terms of consultation or the capacity internally to deliver the changes”.²⁰ On the other hand, Amanda Campbell suggested that “a lot of the activity we have set out in the strategy is very ambitious”, particularly in the context of the spending reductions that the PHSO must make.²¹

13. Its settlement in the 2015 Spending Review requires the PHSO to make a 24% real terms reduction in its spending by the end of 2018–19.²² However, the PHSO negotiated a funding profile that allowed it to defer making significant reductions in spending until 2017–18, effectively requiring it to deliver the whole 24% reduction over 2017–18 and 2018–19.²³

14. This was on the assumption that the then Ombudsman’s five-year strategic plan for transforming the PHSO introduced in 2013 would, by 2017, have implemented a new operating model that would then allow the PHSO to make significant efficiencies.²⁴ The new strategy also reflected the decision to radically increase the number of investigations the PHSO took on, from 467 investigations in 2012–13 to 3,900 the following year.²⁵

15. However, in the judgement of the current Ombudsman his predecessor’s strategy had “not delivered what it intended to deliver”.²⁶ There were significant backlogs within the system, with cases taking an average of 234 days to complete in 2016–17.²⁷ There remained a need to make the PHSO’s case-handling “more professional” including introducing a new-case handling model, improve training for staff, and to reconnect with stakeholders.²⁸ The PHSO is also in the process of re-organising its structures and relocating functions from London to Manchester in order to reduce costs.²⁹

16. Amanda Campbell stressed that this amounts to “a lot of change all at the same time with a budget that is reducing significantly”, and would result in the PHSO’s performance on investigating cases in a timely way falling in the current year, but that it would improve again after that.³⁰

18 Parliamentary and Health Service Ombudsman, [“Our Strategy 2018–21: Delivering an exemplary ombudsman service”](#) 16 April 2018.

19 Q11

20 Q10

21 Q16

22 Parliamentary and Health Services Ombudsman, [“Main Supply Estimate for 2017–18: Memorandum for the House of Commons Public Administration and Constitutional Affairs Committee”](#), November 2017

23 *ibid*

24 *ibid*

25 PHSO Annual report 2016–16, p 9

26 Q12

27 PHS49

28 Q9

29 Q12

30 Q12

17. Mr Behrens told us that he would, “not be backward in coming forward arguing for resource in the spending rounds to come” but accepted that it would have to, “be on the basis that we have addressed the inefficiencies inside the organisation to make sure that people can be confident that if we do get a more generous allocation we will spend it wisely”.³¹ It is currently unclear what systems the Ombudsman intends to put in place to provide this assurance, despite the 2015 Health Committee recommendation that, “an external audit mechanism be established to benchmark and assure the quality of Ombudsman investigations.”³² The National Audit Office (NAO), the PHSO’s external auditors, only provides a financial audit which does not examine the value for money of the PHSO’s spending or assure the quality of its case handling. The Corporation Sole model prescribed in the PHSO’s underpinning legislation also prevents the formal establishment of a non-executive board to oversee the work of the PHSO and Ombudsman.³³ This is addressed in paragraph 21 of this report.

18. **We welcome the Ombudsman’s commitment to consulting widely on his new strategic plan, and the recognition of the need for it to focus on improving its core functions and reconnecting with its stakeholders. The Committee recognises the challenges the new Ombudsman faces in making the reforms he has identified and delivering the savings he is required to make. We note that even the “modest” draft objectives were described as “very ambitious” to deliver by his Chief Executive; and welcome her honesty that delivering long-term improvements may require some short-term increase in the time PHSO takes to complete cases.**³⁴

19. **We will hold the Ombudsman to account for delivering the objectives he is setting and that he has assured us will be deliverable given the resources he has. We also expect the PHSO to continue to be transparent and candid about the impact the change programme is having on its performance, and willing to adjust its strategy if necessary. We will judge the PHSO on the impact it has on public services, the value for money it provides, and the confidence it inspires in complainants, other stakeholders and the public.**

20. *The Committee is in no doubt about the financial challenge that the PHSO faces. However, we also agree with the Ombudsman that before the PHSO can make the case for more funding, it will need to demonstrate that it is spending its current funding well. Given its past problems an external audit mechanism is required that will provide robust assurance of the value for money of the PHSO’s operations to its Board, the Committee and the public. We recommend that the Ombudsman asks his non-executive directors to commission this, and report back to us.*

31 Q20

32 Health Select Committee, Fourth Report of Session 2014–15 “[Complaints and Raising Concerns](#)” HC 350, 21 January 2015, para 91.

33 Public Administration Select Committee, Fourteenth Report of Session 2013–14, “[Time for a People’s Ombudsman Service](#)”, HC 655, 24 April 2014.

34 Q13

Future Public Service Ombudsman

21. One complication in the PHSO's future planning is the proposed merger of it with the Local Government and Social Care Ombudsman (LGO), in-line with our predecessor Committee's recommendation.³⁵ The Government published a draft Bill in 2016, but has yet to indicate when it might introduce the Bill to Parliament.³⁶ The Bill contains several important reforms. It would reflect the reality of the increasing blurring of lines between health and social care as experienced by individuals. It would update the PHSO's antiquated institutional structures and procedures, which are prescribed by the current legislation. This includes replacing the present Corporation Sole with a proper public body governed by an independently appointed non-executive board to provide for proper internal governance and oversight of the Ombudsman. The PHSO currently has a board that includes eight non-executive directors, but they are appointed by the Ombudsman.³⁷

22. The draft Bill also provides for open public access to the new Ombudsman service, in line with other modern ombudsman services, by removing the 'MP filter' on complaints about Government Departments.³⁸

23. The new draft Public Service Ombudsman Bill is awaiting pre-legislative scrutiny. We are clear that it is a vehicle for implementing several of our predecessor Committee's recommendations that are needed to bring the governance and operations of the Ombudsman into the twenty-first century. We have no doubts about the quality of the individuals who act as non-executive directors of the PHSO, but the Corporation Sole model is no longer fit for purpose. Notwithstanding the Bill's content, the continuing uncertainty has an adverse impact on the PHSO, and the Local Government and Social Care Ombudsman (LGO). Together, their ability to plan is being impeded and this risks wasting public money. We, therefore, expect the Government to provide clarity about its intentions for pre-legislative scrutiny of the Bill, and about the timetable to implement this new legislation to allow the PHSO and LGO to plan with some confidence.

24. We recommend that the Government should invite the House of Lords to join the House of Commons in setting up a joint committee to conduct the pre-legislative scrutiny of the draft Public Service Ombudsman Bill as soon as possible. In its response to this report, the Government should provide the PHSO and LGO a date by which it intends to have the new legislation in place to allow them to plan with some confidence.

Staff engagement

25. The PHSO's Annual Report for 2016–17 stated that, "we can only achieve success if we have the commitment and buy-in of our most important resource; the people who work for us."³⁹ The new strategic plan makes clear that the leadership of the PHSO see

35 Public Administration Select Committee, Fourteenth Report of Session 2013–14, "[Time for a People's Ombudsman Service](#)", HC 655, 24 April 2014. Paras 35–44

36 Cabinet Office, "[Draft Public Service Ombudsman Bill](#)" CM 9374, December 2016

37 PHSO "[Members of the Board](#)" & PHSO "[The Board](#)" both accessed 28/03/2018

38 Cabinet Office "Draft Public Service Ombudsman Bill"

39 PHSO Annual Report 2016–17, p 25.

their staff as their “single most important resource”.⁴⁰ Central to delivering their new strategy is the development and implementation of accredited professional training for their case handlers.⁴¹

26. However, Amanda Campbell reported that within the 2016 staff survey, completed before she took up her role, “there were some really poor results. Some were lower than I had seen anywhere in my 30 years in public service and some were very specifically directed at the leadership of the organisation.”⁴² She explained that the senior leadership at the PHSO had invested heavily in improving staff perceptions of the management of the organisations and as a result, “the score has gone from 19% last year to 64% this year with regard to visible leadership. That is because of a lot of effort from leaders across the organisation, but it is still a work in progress. 64% is still not high enough, as far as I am concerned.”⁴³ Overall employee engagement had risen from 52% to 60% in 2017, only one percentage point below the Civil Service benchmark.⁴⁴

27. Both Rob Behrens and Amanda Campbell touched on the challenges individual staff members can face in their interactions with, often distressed, members of the public,⁴⁵ and in dealing with casework that is potentially distressing for the investigators.⁴⁶ Ms Campbell highlighted that the PHSO was implementing training and support for staff members to help them manage the “vicarious trauma” staff may experience as a result of their work in response.⁴⁷

28. We recognise that the staff of the PHSO are central to its success. They are asked to do a difficult job, and the last few years has been a period of significant and ongoing uncertainty owing both to the organisation’s restructuring and the unexpected turnover in senior leadership. We welcome the improvement in staff engagement, but we agree with Amanda Campbell that more needs to be done.

29. We also welcome the enhanced support to PHSO staff to manage “vicarious trauma”. The wellbeing of PHSO staff is important in and of itself. However, given the nature of their work it is also vital for their ability to deal supportively and empathetically with complainants. We also strongly support the PHSO’s wider plans, set out in their new strategic plan, to invest in training their staff and to developing professional accreditation for case handlers.

40 PHSO “Our Strategy 2018–21” p 5

41 Ibid & Q9

42 Q83

43 Q84

44 Q83

45 Q36 & Q54

46 Q55

47 Q55

3 PHSO’s performance in handling complaints

30. All the written evidence we received, except for the PHSO’s own submission, was from people and organisations who had complained to the PHSO and were in some way unhappy with the way their complaint had been handled. The Committee cannot examine individual cases. However, it does consider the examples of individual’s experiences it sees in choosing which elements of the PHSO’s performance to focus on in scrutiny. It may also examine reports on individual cases that the Ombudsman lays before Parliament.⁴⁸

Timeliness of decisions

31. The excessive length of time taken to decide whether to investigate complaints, and then to carry out the investigation, was a common theme in the evidence to the Committee.⁴⁹

32. Amanda Campbell accepted that, “over the last few years it has just taken too long to deal with complaints. We have not been consistently able to provide the quality of service that we would wish to”.⁵⁰ The PHSO was responding to this through introducing new training for staff, including on communicating with complainants, and new processes that would reduce the number of “hand-offs” of complaints between different staff members.⁵¹ The average length of time taken to complete a full investigation of a complaint in 2016–17 had fallen to 234 days from 255 the previous year, with waiting time at each stage falling as well, as a result of these improvements,⁵² although Amanda Campbell stated that an average of over 200 days was still, “simply unacceptable”.⁵³

33. Some of these issues were apparent in the investigation into the death of Averil Hart in December 2012.⁵⁴ The Ombudsman’s final report was issued on 8 December 2017, three and a half years after the original complaint had been made to the PHSO. Mr Behrens accepted this was too long and he had apologised to Ms Hart’s family.⁵⁵ He told us that the, “resourcing of the investigation lacked continuity” prior his taking up the post of Ombudsman in April 2017.⁵⁶

34. We remain concerned at the length of time that PHSO investigations take to complete, not least because of the added distress this can cause to complainants. We are also clear that increasing the speed of investigations should not come at the cost of compromising their quality, and we therefore accept that delivering significant improvements may take some time. We note that, although the PHSO has said an average of 200 days is unacceptable, it has not defined what it thinks would be an acceptable benchmark.

48 See for example, Public Administration and Constitutional Affairs Select Committee, Seventh Report of Session 2016–17, “[Will the NHS never learn? Follow-up to PHSO report ‘Learning from Mistakes’ on the NHS in England](#)” HC 743, 31 January 2017

49 PHS29

50 Q40

51 Q40

52 Q38 & PHS49 para 6

53 Q37

54 PHSO Ignoring the Alarms

55 Q1

56 Q1

35. *The Committee recommends that the PHSO publishes what average length of investigation it is aiming for and by when it intends to achieve it. The Committee will investigate the specific issues raised by the report into Ms Hart’s death and the lessons to be learned, including from the failings in the investigation, at a later date.*

Learning from mistakes

36. The Ombudsman paid compensation to 13 separate complainants in 2016–17 in relation to harm caused by the PHSO. This totalled £26,333, but £24,855 was in relation to legal costs on a single case.⁵⁷ The 13 cases in 2016–17 were 0.3% of the 4,239 total decisions PHSO made.⁵⁸ Amanda Campbell stressed that the PHSO had recently introduced a “learning and feedback model” that seeks to capture learning from complaints and asks: “Are we doing things wrong systematically? Is it because those are failing in process, is it a failing in training or is it that an individual person or team needs to have more support?”⁵⁹

37. *Given the nature of the PHSO’s work, and the number of complaints that it handles, it is inevitable that mistakes will be made, or the service provided to some complainants will slip below the standards the PHSO sets itself. However, these should be minimised, and the need to pay compensation rare. Complainants to the PHSO are already, by definition, dissatisfied with their treatment by the public sector so it is imperative the PHSO seeks to avoid causing further distress and further undermining public confidence in public services. We therefore welcome the approach to learning and feedback that is being implemented. We expect the PHSO to be able to provide evidence in the future of the improvements that have resulted. We also recommend that in future the PHSO publishes in its annual report how many times it has offered compensation as part of its wider commitment to transparency.*

Correcting mistakes

38. The Ombudsman’s ability, and willingness, to correct mistakes in his reports, or add to them where an investigation has been based on incomplete or incorrect information was raised in the written evidence by the Brooks family.⁶⁰ In cases where issues with an original report are not minor drafting errors the PHSO’s normal policy is to open a new investigation, and issue a further or supplementary report with new findings.⁶¹ However, it had been previous Ombudsmans’ understanding that they did not obviously have the power, on their own initiative, to formally quash a report once it had been made.⁶² Instead a complainant would need to seek a judicial review of the Ombudsman’s decision.

39. The Brooks family had asked the previous Ombudsman to withdraw a report based on an investigation that she had accepted was flawed prior to carrying out a new investigation.⁶³ The family were concerned that in the interim the original flawed report was being relied upon in other proceedings, such as a coroner’s inquest, by the NHS Trust and professionals they had complained about.⁶⁴

57 Rob Behrens, [Further written evidence](#), 12 January 2018

58 PHSO Annual Report 2016–17 p.10. It is unclear how many of the 13 cases where compensation was offered related to decisions made in 2016–17.

59 Q57

60 PHS 46

61 [Correspondence from Rob Behrens, 1 February 2018](#)

62 *ibid*

63 PHS 46

64 *ibid*

40. Amanda Campbell stated, on 12 December, that once the PHSO had published a report, “in law our legislation requires us to quash the report in court and that we have no powers to withdraw a report once written.”⁶⁵ Mr Behrens has subsequently taken the opposite view.⁶⁶ His policy will be that in exceptional circumstances, he will quash a decision on his own initiative, and was intending to do so in relation to the case that had been raised with the Committee.⁶⁷

41. We welcome the Ombudsman’s change in policy, and the clear statement that, in exceptional circumstances, the Ombudsman will quash an inaccurate or incorrect report. It is clearly reasonable that, where the Ombudsman accepts a decision is flawed and there is risk that if it is not withdrawn prior to a new investigation being completed it will do harm, he should be able to withdraw it. However, we recognise that the law is not certain on this point.

42. We therefore recommend that the Government include unambiguous powers in the Public Services Ombudsman legislation to allow the Ombudsman to withdraw his reports in exceptional circumstances. This continuing legal uncertainty is another reason why the legislation should be brought forward at an early opportunity. If the Government intends not to legislate to create the Public Services Ombudsman in the foreseeable future it should identify an alternative legislative vehicle to amend the existing legislation.

PHSO’s service charter

43. The PHSO introduced its new Service Charter in the summer of 2016. This sets out 14 commitments to complainants about the service they can expect.⁶⁸ The PHSO publishes quarterly reports on its internal “Casework Process Assurance” against them, and the results of an independent survey of the views of 600 complainants.⁶⁹ Amanda Campbell explained that they were leading the Ombudsman sector in systematically surveying their complainants, and therefore it was difficult to establish external benchmarks to measure themselves against.⁷⁰ Instead PHSO would monitor changes across time to track their progress and identify areas that required greater attention.⁷¹ Service charter data has been published quarterly on the Ombudsman’s website since the third quarter of 2016–17.⁷²

44. There are significant gaps on some commitments between the score produced by the PHSO’s casework process assurance and the views of complainants. In quarters 3 & 4 of 2016–17 the largest gap was on commitment eight: “We will gather all the information we need, including from you and the organisation you have complained about before we make our decision” at 53 percentage points (96% to 43%).⁷³ In its written evidence, the PHSO suggested that such gaps were “because complainant feedback is based on questions regarding the complainant’s experience of our service, while the CPA [Casework Process Assurance] data assesses whether we have followed the correct approach in reaching our

65 Q66

66 [Correspondence from Rob Behrens, 1 February 2018](#)

67 [Correspondence from Rob Behrens, 1 February 2018](#)

68 Parliamentary and Health Service Ombudsman [“Our Service Charter”](#), accessed 02/02/2018

69 “Our Service Charter” PHSO

70 Q50

71 Q50

72 Public and Health Services Ombudsman [“Performance Against our Service Charter”](#), accessed 02/02/2018

73 PHSO Annual Report 2016–17 p.15

decision.”⁷⁴ In its Annual Report the PHSO sets out that overall levels of satisfaction with its services tend to be related to its decisions on an individual’s case; 81% of those whose complaints were upheld were satisfied compared to only 51% of those whose complaints were not upheld.⁷⁵

45. We welcome the innovation of the Service Charter, and the commitment to learning and improving the PHSO’s service to the complainants it represents. It will be an important tool for the PHSO, Parliament and the public to track and understand the PHSO’s performance over time. For that reason, we expect that the PHSO will continue to collect and publish this data in comparable form for the foreseeable future.

46. We accept that it is inevitable that the outcome of their case will colour the views of complainants regarding the overall service provided by the PHSO. However, we expect the PHSO to keep those commitments where there is a large gap between complaints perceptions and the casework process assurance scores under review. It should also provide assurance that the gap is not a result of failings in their processes.

Impartiality and unconscious bias

47. The one commitment the PHSO’s service charter does not ask for complainants’ views on is number ten: “We will evaluate the information we’ve gathered and make an impartial decision on your complaint”.⁷⁶ Many written submissions suggested that the PHSO’s investigators are biased towards professionals or the body being investigated, called ‘bodies in jurisdiction’ by the PHSO.⁷⁷ In evidence Amanda Campbell told us, “I have exactly the same said to me from bodies in jurisdiction; they believe that we are biased towards complainants.”⁷⁸ She also highlighted that all PHSO staff undertake “unconscious bias” training, but accepted that sometimes staff “did not get it right” in communicating with complainants.⁷⁹

48. Mr Behrens summarised his position as, “if you are not independent as an Ombudsman, you might as well give up.”⁸⁰ He also stated that “us not being an advocate for complainants is very important to get across. One of the issues that needs to be borne in mind by some of our critics is that the complaint belongs to the complainant. We have a responsibility to investigate it impartially, but the decision belongs to the Ombudsman.”⁸¹ However, he accepted that it might be appropriate to include the question on impartiality in the PHSO’s survey of complainants.⁸²

74 PHS 49 para 13

75 PHSO Annual Report 2016–17 p14

76 PHSO “Our Service Charter”

77 See, for example, PHS 26 para 36, PHS 35, or PHS 37 para 2

78 Q41

79 Q52 & 54

80 Q41

81 Q42

82 Q43

49. Specific questions have been raised about the PHSO’s use of independent clinical experts, including whether they should be identified and their advice shared with parties to a complaint to allow it to be challenged.⁸³ The PHSO’s policy of sharing draft reports with bodies in jurisdiction was also criticised in some of the written submission we received.⁸⁴ Mr Behrens confirmed to us that, in the future, all parties would have equal access to reports, and that the PHSO was reviewing its use of external clinical experts.⁸⁵

50. We agree that impartiality and independence is central to the effectiveness of the Ombudsman. His decisions must belong to him. However, the public and Parliament must also have confidence that the PHSO is impartial. A core role of the Ombudsman is providing assurance to the public that if they suffer injustice at the hands of public services there is an impartial person they can turn to, whether they ever need to or not. This is important for maintaining public confidence in public services and public servants.⁸⁶

51. We have no doubt that the PHSO is committed to taking its decisions impartially. However, as it recognises through the need for unconscious bias training, there is always a risk that investigators will display unconscious bias towards complainants or bodies in jurisdiction. Given the centrality of impartiality to PHSO’s culture and self-image, it is also possible that the PHSO staff carrying out quality assurance of the handling of PHSO investigations will display unconscious bias towards their colleagues. We recognise that external perceptions of independence and impartiality will be in themselves only a partial view, but they are a potentially important additional reference point for both the PHSO and Parliament to use in monitoring the PHSO’s performance.

52. We therefore recommend that the PHSO does ask complainants if they perceive it as making decisions impartially as part of the Service Charter, and systematically seek and publish the view of bodies in jurisdiction. We support the commitment to equal access to draft reports and other information between all parties to a complaint.

Data protection

53. The PHSO recorded five serious losses of personal data that they had to report to the Information Commissioner in 2016–17, all involving data relating to complaints it was investigating.⁸⁷ For comparison the Care Quality Commission reported one loss and the Local Government Ombudsman none for the same period.⁸⁸ The PHSO had reported a total of two losses for the three preceding financial years.⁸⁹

83 See, for example, PHS 42 paras 5–8

84 PHS 26

85 Q41

86 See for example Richard Crossman in moving the Second Reading of the Parliamentary Commissioners Bill, HC Deb 18 December 1966 vol 734 [col 44](#)

87 Rather than personal data of staff. PHSO Annual Report pp. 46–48

88 Care Quality Commission, [“Annual Report and accounts: 2016–17”](#), HC (2017–19) 200, 18 July 2017; Local Government Ombudsman, [“Making a Difference: Annual Reports & Accounts 2016–17”](#), HC (2017–19) 181, 12 July 2017.

89 Parliamentary and Health Services Ombudsman, [“The Ombudsman’s Annual Report and Accounts 2015–16”](#) HC (2016–17) 779, 3 November 2016, [“The Ombudsman’s Annual Report and Accounts 2014–15”](#) HC (2015–16) 570, 9 November 2015; and [“A Voice for Change: The Ombudsman’s Annual Report and Accounts 2013–14”](#) HC (2014–15) 536, 18 July 2014.

54. Amanda Campbell told us that three of the incidents in 2016–17 related to couriers losing files in transit or being unable to account for their delivery.⁹⁰ The PHSO recorded similar incidents in 2014–15 and 2015–16.⁹¹ Ms Campbell, however, assured the Committee that PHSO was “very aware of data security. We take it very seriously”.⁹² She added “We train all our staff every year routinely in data handling... they are very good at telling us when there have been issues and incidents, so that we can make sure that they are systemic issues and the we can follow them up.”⁹³

55. Given the very sensitive nature of the personal data relating to complainants that the PHSO routinely handles, any serious loss must be a concern. We recognise, that, given the thousands of cases that PHSO handles annually, it would be unreasonable to expect it to never have an issue. However, the number of losses last year compared to similar organisations and the repeated losses of data by couriers is very concerning. We will monitor these issues closely in future years, and expect the leadership of the PHSO to take swift action if a trend of serious losses develops.

90 Q81

91 PHSO Annual Reports 2014–15 and 2015–16

92 Q80

93 Q81

4 Historic complaints

56. A number of the submissions we received were about cases where the original incident had occurred a number of years previously. In some, such as the death of Averil Hart, the PHSO investigation had taken several years to complete.⁹⁴ In others, complainants had spent a number of years seeking to get the PHSO to correct what the complainants saw as failures in the PHSO’s original investigation or to change its decision.⁹⁵ The Ombudsman drew a distinction between, on the one hand, the need for the PHSO to engage better, “with complainants with longstanding grievances” about how their case had been dealt with and, on the other, whether complainants should be able to seek an external review of the Ombudsman’s decisions.⁹⁶ He rejected the latter as, “contrary to the constitutional principle of the Ombudsman” as the “independent complaint handler of last resort”.⁹⁷

57. Mr Behrens highlighted a small number of historic cases that he judged might warrant further independent investigation, because of concerns about the original investigations.⁹⁸ He was clear that it would not be appropriate for the PHSO to undertake these.⁹⁹ In its report into the quality of NHS Complaints in 2016 our predecessor Committee endorsed the:

... proposal for the re-opening of historic “unresolved grievances”, but only where there is a clear argument that doing so would assist in improving patient safety in the future, or where serious outstanding legitimate grievances persist. This process might take the form of a single public inquiry, to consider which legacy cases to review, to hear the selected cases, and make recommendations arising from them. This should be seen in the context of other wide-reaching inquiries in recent years, such as the public inquiry into historic child sexual abuse, the Hillsborough Independent Panel’s inquiry into the Hillsborough disaster, and the Saville inquiry into the events of Bloody Sunday. The purpose of this single public inquiry would be to provide closure to those affected by patient safety incidents, which cannot otherwise be obtained.¹⁰⁰

58. In its response, the Government stated that it, “had an open mind” on the issue but was concerned that a single inquiry, “might prove unsustainable”.¹⁰¹ It did, however, commit to developing alternative options, although none have subsequently been published.¹⁰²

94 PHSO “Ignoring the Alarms”

95 See for example PHS 46

96 Q2&3

97 Q3 & [Correspondence from Rob Behrens of 12 January 2018](#)

98 Q2–8

99 Q3

100 Public Administration and Constitutional Affairs Committee, First Report of Session 2016–17 [PHSO Review: Quality of NHS complaints investigations](#) HC 94, 2 June 2016, para 81.

101 Public Administration and Constitutional Affairs Committee, Second Special Report of Session 2016–17, [PHSO review: Quality of NHS complaints investigations: Government response to the Committee’s First Report of Session 2016–17](#) HC 742, 18 October 2016.

102 *ibid*

59. *We agree that the PHSO is not the correct body to carry out inquiries into historic cases. However, there remains a need for them to be addressed, both in the interests of the families involved and in ensuring that any safety lessons that can still be learnt are. We therefore endorse and repeat our predecessor Committee's recommendation; that the Department of Health and Social Care should develop a proportionate, time limited, mechanism to independently investigate and address those cases where legitimate questions or grievances remain. There is also a need to address local complaint handling and investigations in the NHS to ensure that there are fewer failed investigations in the future, we address this in the next chapter.*

5 Improving public services

60. The PHSO define part of their role as “sharing the unique insight from our casework with Parliament... [and] more widely, with the organisations we investigate, regulators and policy makers to help them improve complaint handling and public service delivery.”¹⁰³ The PHSO highlighted a number of cases where it judged that its recommendations had contributed to changes in policy, for instance changes in the regulation of midwifery, or raised awareness about certain risks, for example around recognition and treatment of sepsis within the NHS.¹⁰⁴

Implementation of recommendations

61. In its annual report, the PHSO state that for 99% of the complaints it completed the investigation for in 2016–17, the organisation involved agreed to implement the PHSO’s recommendations.¹⁰⁵ However, the PHSO does not report how many of its recommendations were implemented, and it has been criticised for its failure to properly follow up its recommendations by the Patients Association and others.¹⁰⁶ Mr Behrens explained that while the PHSO does ask organisations “whether or not they have implemented the [PHSO’s] report”, he intended to change how the question was asked and committed that “it would be different” in their next annual report.¹⁰⁷

62. **We welcome the Ombudsman’s commitment to providing further information on whether his recommendations are implemented in the future. It will also be important for the PHSO be able to provide evidence on whether the implementation of its recommendations have the positive effect on services it expects; both for its own learning and in any assessment of the PHSO’s value for money.**

63. *We therefore recommend that the Ombudsman publishes in his annual report how many of his recommendations are implemented as well as how many are accepted. In the longer term, we also recommend the PHSO seeks to evaluate the impact of its recommendations.*

Improving local complaint handling

64. With regard to improving complaint handling at a local level, especially in the NHS, the Ombudsman pointed towards the activity set out under objective three of the PHSO’s draft strategic plan, which includes the intention to develop “new tools and training approaches” to help improve the capacity of local complaint handlers.¹⁰⁸ This is, in part, necessary because, as the Ombudsman explained, “it is entirely clear when you talk to people who have responsibility for complaints in hospitals that they do not believe that they are providing the optimum service or that they have the resources, the skills or the

103 PHS 49 para 23.

104 Ibid paras 26 & 27

105 PHSO Annual Report p.11

106 Q77, The Patients Association, [“Follow-up report to the March 2015 Patients Association publication on the Parliamentary and Health Service Ombudsman”](#), December 2016.

107 Q74 & 77

108 PHS 49, Annex

access to the clinicians to come up with the necessary answers.”¹⁰⁹ The Ombudsman had made an offer to the local NHS Trusts to “provide an element of skills development, but we [the PHSO] cannot do it on our own.”¹¹⁰

65. Both our predecessor Committee and the Health Committee in the previous Parliament highlighted serious failing in the NHS’s local complaint handling and investigations in recent years.¹¹¹ In February 2016 the then Parliamentary Under-Secretary for Care Quality, Ben Gummer MP, told our predecessors that improving the handling of complaints was a “bit of unfinished business”, and that he hoped “that we will be able to come back to you with some really good policy in a few months’ time.”¹¹²

66. The draft Health Services Safety Investigations Bill will provide the legislative underpinning for the new independent Health Service Safety Investigations Branch (HSSIB).¹¹³ As our predecessor Committees recommended, this includes a remit to support the improvement of local investigations into clinical safety incidents.¹¹⁴ However, HSSIB will only investigate a small number of incidents itself. The poor quality of local investigations into safety incidents is an issue in many complaints, but the problems go much wider both in-terms of complaints about non-clinical matters and the wider cultural resistance to learning from complaints.¹¹⁵

67. We welcome the recent announcement of a joint committee of both House of Parliament to carry out pre-legislative scrutiny on the draft Health Service Safety Investigations (HSSI) Bill. However, the permanent establishment of an independent Health Services Safety Investigation Branch with a remit to improve local investigations is a necessary but not sufficient step to improve local complaints handling. We commend the focus in the PHSO’s draft strategic plan to using its own learning to help improve complaints handling in bodies in jurisdiction, especially within the NHS. However, improving complaints handling is the responsibility of the leadership of the NHS, and ultimately Ministers. This includes ensuring that local NHS leaders prioritise and properly resource complaints handling.

68. *The Department of Health and Social Care should provide the Committee with an update on its progress on dealing with the “unfinished business” of local complaints handling the then Minister Ben Gummer MP identified in 2016, and the improvements that it has made. The Government should also ensure that once the Joint Committee scrutinising the HSSI Bill has reported that the revised Bill is introduced to Parliament as quickly as possible.*

109 Q79

110 Q79

111 See for example; Public Administration and Constitutional Affairs Select Committee, Seventh Report of Session 2016–17, “[Will the NHS never learn? Follow-up to PHSO report ‘Learning from Mistakes’ on the NHS in England](#)” HC 743, 31 January 2017; PACAC “Quality of NHS complaints investigations” 2016; and Health Committee “Complaints and Raising Concerns” 2015.

112 [Oral evidence taken on 23 February 2016, HC \(2015–16\) 792, Q 8](#)

113 Department for Health, “Draft Health Service Safety Investigations Bill” [CM 9497](#), September 2017

114 The creation of a HSSIB like body was first recommended in Public Administration Select Committee, Sixth Report of Session 2014–15 “[Investigating Clinical incidents in the NHS](#)” HC 886, 27 March 2015

115 See PACAC, “PHSO Review: Quality of NHS complaints investigations” and “Will the NHS never learn?”

Conclusions and recommendations

Future strategy

1. We welcome the Ombudsman’s commitment to consulting widely on his new strategic plan, and the recognition of the need for it to focus on improving its core functions and reconnecting with its stakeholders. The Committee recognises the challenges the new Ombudsman faces in making the reforms he has identified and delivering the savings he is required to make. We note that even the “modest” draft objectives were described as “very ambitious” to deliver by his Chief Executive; and welcome her honesty that delivering long-term improvements may require some short-term increase in the time PHSO takes to complete cases. (Paragraph 18)
2. We will hold the Ombudsman to account for delivering the objectives he is setting and that he has assured us will be deliverable given the resources he has. We also expect the PHSO to continue to be transparent and candid about the impact the change programme is having on its performance, and willing to adjust its strategy if necessary. We will judge the PHSO on the impact it has on public services, the value for money it provides, and the confidence it inspires in complainants, other stakeholders and the public. (Paragraph 19)
3. *The Committee is in no doubt about the financial challenge that the PHSO faces. However, we also agree with the Ombudsman that before the PHSO can make the case for more funding, it will need to demonstrate that it is spending its current funding well. Given its past problems an external audit mechanism is required that will provide robust assurance of the value for money of the PHSO’s operations to its Board, the Committee and the public. We recommend that the Ombudsman asks his non-executive directors to commission this, and report back to us.* (Paragraph 20)
4. The new draft Public Service Ombudsman Bill is awaiting pre-legislative scrutiny. We are clear that it is a vehicle for implementing several of our predecessor Committee’s recommendations that are needed to bring the governance and operations of the Ombudsman into the twenty-first century. We have no doubts about the quality of the individuals who act as non-executive directors of the PHSO, but the Corporation Sole model is no longer fit for purpose. Notwithstanding the Bill’s content, the continuing uncertainty has an adverse impact on the PHSO, and the Local Government and Social Care Ombudsman (LGO). Together, their ability to plan is being impeded and this risks wasting public money. We, therefore, expect the Government to provide clarity about its intentions for pre-legislative scrutiny of the Bill, and about the timetable to implement this new legislation to allow the PHSO and LGO to plan with some confidence. (Paragraph 23)
5. *We recommend that the Government should invite the House of Lords to join the House of Commons in setting up a joint committee to conduct the pre-legislative scrutiny of the draft Public Service Ombudsman Bill as soon as possible. In its response to this report, the Government should provide the PHSO and LGO a date by which it intends to have the new legislation in place to allow them to plan with some confidence.* (Paragraph 24)

6. We recognise that the staff of the PHSO are central to its success. They are asked to do a difficult job, and the last few years has been a period of significant and ongoing uncertainty owing both to the organisations restructuring and the unexpected turnover in senior leadership. We welcome the improvement in staff engagement, but we agree with Amanda Campbell that more needs to be done. (Paragraph 28)
7. We also welcome the enhanced support to PHSO staff to manage “vicarious trauma”. The wellbeing of PHSO staff is important in and of itself. However, given the nature of their work it is also vital for their ability to deal supportively and empathetically with complainants. We also strongly support the PHSO’s wider plans, set out in their new strategic plan, to invest in training their staff and to developing professional accreditation for case handlers. (Paragraph 29)

PHSO’s performance in handling complaints

8. We remain concerned at the length of time that PHSO investigations take to complete, not least because of the added distress this can cause to complainants. We are also clear that increasing the speed of investigations should not come at the cost of compromising their quality, and we therefore accept that delivering significant improvements may take some time. We note that, although the PHSO has said an average of 200 days is unacceptable, it has not defined what it thinks would be an acceptable benchmark. (Paragraph 34)
9. *The Committee recommends that the PHSO publishes what average length of investigation it is aiming for and by when it intends to achieve it. The Committee will investigate the specific issues raised by the report into Ms Hart’s death and the lessons to be learned, including from the failings in the investigation, at a later date.* (Paragraph 35)
10. *Given the nature of the PHSO’s work, and the number of complaints that it handles, it is inevitable that mistakes will be made, or the service provided to some complainants will slip below the standards the PHSO sets itself. However, these should be minimised, and the need to pay compensation rare. Complainants to the PHSO are already, by definition, dissatisfied with their treatment by the public sector so it is imperative the PHSO seeks to avoid causing further distress and further undermining public confidence in public services. We therefore welcome the approach to learning and feedback that is being implemented. We expect the PHSO to be able to provide evidence in the future of the improvements that have resulted. We also recommend that in future the PHSO publishes in its annual report how many times it has offered compensation as part of its wider commitment to transparency.* (Paragraph 37)
11. We welcome the Ombudsman’s change in policy, and the clear statement that, in exceptional circumstances, the Ombudsman will quash an inaccurate or incorrect report. It is clearly reasonable that, where the Ombudsman accepts a decision is flawed and there is risk that if it is not withdrawn prior to a new investigation being completed it will do harm, he should be able to withdraw it. However, we recognise that the law is not certain on this point. (Paragraph 41)

12. *We therefore recommend that the Government include unambiguous powers in the Public Services Ombudsman legislation to allow the Ombudsman to withdraw his reports in exceptional circumstances. This continuing legal uncertainty is another reason why the legislation should be brought forward at an early opportunity. If the Government intends not to legislate to create the Public Services Ombudsman in the foreseeable future it should identify an alternative legislative vehicle to amend the existing legislation. (Paragraph 42)*
13. We welcome the innovation of the Service Charter, and the commitment to learning and improving the PHSO's service to the complainants it represents. It will be an important tool for the PHSO, Parliament and the public to track and understand the PHSO's performance over time. For that reason, we expect that the PHSO will continue to collect and publish this data in comparable form for the foreseeable future. (Paragraph 45)
14. We accept that it is inevitable that the outcome of their case will colour the views of complainants regarding the overall service provided by the PHSO. However, we expect the PHSO to keep those commitments where there is a large gap between complaints perceptions and the casework process assurance scores under review. It should also provide assurance that the gap is not a result of failings in their processes. (Paragraph 46)
15. We agree that impartiality and independence is central to the effectiveness of the Ombudsman. His decisions must belong to him. However, the public and Parliament must also have confidence that the PHSO is impartial. A core role of the Ombudsman is providing assurance to the public that if they suffer injustice at the hands of public services there is an impartial person they can turn to, whether they ever need to or not. This is important for maintaining public confidence in public services and public servants. (Paragraph 50)
16. We have no doubt that the PHSO is committed to taking its decisions impartially. However, as it recognises through the need for unconscious bias training, there is always a risk that investigators will display unconscious bias towards complainants or bodies in jurisdiction. Given the centrality of impartiality to PHSO's culture and self-image, it is also possible that the PHSO staff carrying out quality assurance of the handling of PHSO investigations will display unconscious bias towards their colleagues. We recognise that external perceptions of independence and impartiality will be in themselves only a partial view, but they are a potentially important additional reference point for both the PHSO and Parliament to use in monitoring the PHSO's performance. (Paragraph 51)
17. *We therefore recommend that the PHSO does ask complainants if they perceive it as making decisions impartially as part of the Service Charter, and systematically seek and publish the view of bodies in jurisdiction. We support the commitment to equal access to draft reports and other information between all parties to a complaint. (Paragraph 52)*

18. Given the very sensitive nature of the personal data relating to complainants that the PHSO routinely handles, any serious loss must be a concern. We recognise, that, given the thousands of cases that PHSO handles annually, it would be unreasonable to expect it to never have an issue. However, the number of losses last year compared to similar organisations and the repeated losses of data by couriers is very concerning. We will monitor these issues closely in future years, and expect the leadership of the PHSO to take swift action if a trend of serious losses develops. (Paragraph 55)

Historic complaints

19. *We agree that the PHSO is not the correct body to carry out inquiries into historic cases. However, there remains a need for them to be addressed, both in the interests of the families involved and in ensuring that any safety lessons that can still be learnt are. We therefore endorse and repeat our predecessor Committee's recommendation; that the Department of Health and Social Care should develop a proportionate, time limited, mechanism to independently investigate and address those cases where legitimate questions or grievances remain. There is also a need to address local complaint handling and investigations in the NHS to ensure that there are fewer failed investigations in the future, we address this in the next chapter.* (Paragraph 59)

Improving public services

20. We welcome the Ombudsman's commitment to providing further information on whether his recommendations are implemented in the future. It will also be important for the PHSO be able to provide evidence on whether the implementation of its recommendations have the positive effect on services it expects; both for its own learning and in any assessment of the PHSO's value for money. (Paragraph 62)
21. *We therefore recommend that the Ombudsman publishes in his annual report how many of his recommendations are implemented as well as how many are accepted. In the longer term, we also recommend PHSO seeks to evaluate the impact of its recommendations.* (Paragraph 63)
22. We welcome the recent announcement of a joint committee of both House of Parliament to carry out pre-legislative scrutiny on the draft Health Service Safety Investigations (HSSI) Bill. However, the permanent establishment of an independent Health Service Safety Investigation Branch with a remit to improve local investigations is a necessary but not sufficient step to improve local complaints handling. We commend the focus in the PHSO's draft strategic plan to using its own learning to help improve complaints handling in bodies in jurisdiction, especially within the NHS. However, improving complaints handling is the responsibility of the leadership of the NHS, and ultimately Ministers. This includes ensuring that local NHS leaders prioritise and properly resource complaints handling. (Paragraph 67)
23. *The Department of Health and Social Care should provide the Committee with an update on its progress on dealing with the "unfinished business" of local complaints handling the then Minister Ben Gummer MP identified in 2016, and the improvements that it has made. The Government should also ensure that once the Joint Committee scrutinising the HSSI Bill has reported that the revised Bill is introduced to Parliament as quickly as possible.* (Paragraph 68)

Formal minutes

Tuesday 17 April 2018

Members present:

Mr Bernard Jenkin, in the Chair

Dame Cheryl Gillan

Dr Rupa Huq

Kelvin Hopkins

Mr David Jones

Draft Report (*PHSO Annual Scrutiny 2016–17*), proposed by the Chair, brought up, and read.

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

Paragraphs 1 to 68 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned til 9.30am on Tuesday 24 April

Witnesses

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

Tuesday 9 January 2018

Question number

Rob Behrens, Parliamentary and Health Service Ombudsman, and **Amanda Campbell**, Chief Executive, Parliamentary and Health Service Ombudsman

[Q1–94](#)

Published written evidence

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

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

- 1 A. Kampalis ([PHS0037](#))
- 2 A1 ([PHS0044](#))
- 3 Carole Bailes ([PHS0047](#))
- 4 Daphne Havercroft ([PHS0040](#))
- 5 Dr David Drew ([PHS0036](#))
- 6 Dr Derek Whitmell ([PHS0020](#))
- 7 Dr Kenneth Nicholson ([PHS0032](#))
- 8 Dr Philip Howard ([PHS0042](#))
- 9 Electrosensitivity UK ([PHS0017](#))
- 10 Fiona Watts ([PHS0016](#))
- 11 Jill Mizen ([PHS0021](#))
- 12 Maggie and Janet Brooks ([PHS0046](#))
- 13 Miss Elise Holton ([PHS0025](#))
- 14 Miss Peggy Banks ([PHS0003](#))
- 15 Mr Alan Reid ([PHS0010](#))
- 16 Mr Andrew Creek ([PHS0048](#))
- 17 Mr Barry Toogood ([PHS0012](#))
- 18 Mr Colin Rock ([PHS0043](#))
- 19 Mr Julian Stell ([PHS0015](#))
- 20 Mr Richard von Abendorff ([PHS0026](#))
- 21 Mr Richard von Abendorff ([PHS0028](#))
- 22 Mr Robert Bird ([PHS0002](#))
- 23 Mr William David Griffiths ([PHS0035](#))
- 24 Mrs Alice Gilbert Scott ([PHS0004](#))
- 25 Mrs Anne Brown ([PHS0006](#))

- 26 Mrs Brenda Prentice ([PHS0011](#))
- 27 Mrs Christine Smith ([PHS0009](#))
- 28 Mrs Dee Speers ([PHS0014](#))
- 29 Mrs Sharon Lamerton ([PHS0038](#))
- 30 Mrs Teresa Steele ([PHS0008](#))
- 31 Ms Keyna Doran ([PHS0034](#))
- 32 Nicholas Gould ([PHS0045](#))
- 33 Nicholas Wheatley ([PHS0029](#))
- 34 Parliamentary and Health Service Ombudsman ([PHS0049](#))
- 35 Paul Roditelev ([PHS0022](#))
- 36 phsothefacts ([PHS0013](#))
- 37 Rosemary Cantwell ([PHS0033](#))
- 38 Vanessa Wood ([PHS0030](#))
- 39 W J Morris ([PHS0019](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2017–19

First Report	Devolution and Exiting the EU and Clause 11 of the European Union (Withdrawal) Bill: Issues for Consideration	HC 484
Second Report	Parliamentary Boundary Reviews: What Next?	HC 559
First Special Report	Will the NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England: Government Response to the Committee's Seventh Report of Session 2016–17	HC 441
Second Special Report	The Future of the Union, part two: Inter-institutional relations in the UK: Government Response to the Sixth Report from the Committee, Session 2016–17	HC 442
Third Special Report	Lessons still to be learned from the Chilcot inquiry: Government Response to the Committee's Tenth Report of Session 2016–17	HC 708
Fourth Special Report	Government Response to the Committee's Thirteenth Report of Session 2016–7: Managing Ministers' and officials' conflicts of interest: time for clearer values, principles and action	HC 731