Parliamentary and Health Service Ombudsman

Celebrating 40 years in 2007

Annual Report 2006-07

Putting principles into practice

HC 838

The Parliamentary and Health Service Ombudsman (PHSO) exists to:

'Provide a service to the public by undertaking independent investigations into complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service.'

Our vision is to:

- Make our service available to all who need it
- Operate open, transparent, fair, customer-focused processes
- Understand complaints and investigate them thoroughly, quickly and impartially, and secure appropriate outcomes
- Share learning to promote improvement in public services

The values which underpin everything we do are:

Excellence

We pursue excellence in all that we do in order to provide the best possible service:

- We seek feedback to achieve learning and continuous improvement
- We operate thorough and rigorous processes to reach sound, evidence-based judgments
- We are committed to enabling and developing our staff so that they can provide an excellent service

Leadership

We lead by example and believe our work should have a positive impact:

- We set high standards for ourselves and others
- We are an exemplar and provide expert advice in complaints handling
- We share learning to achieve improvement

Integrity

We are open, honest and straightforward in all our dealings and use time, money and resources effectively:

- We are consistent and transparent in our actions and decisions
- We take responsibility for our actions and hold ourselves accountable for all that we do
- We treat people fairly

Diversity

We value people and their diversity and strive to be inclusive:

- We respect others, regardless of personal differences
- We listen to people to understand their needs and tailor our service accordingly
- We promote equal access to our service for all members of the community

These values will shape our behaviour, both as an organisation and as individuals working in the Ombudsman's office.

Parliamentary and Health Service Ombudsman

Celebrating 40 years in 2007

Annual Report 2006-07

Session 2006-07

Presented to Parliament pursuant to Section 10(4) of the Parliamentary Commissioner Act 1967 and Section 14(4) of the Health Service Commissioners Act 1993

Ordered by
The House of Commons

to be printed on
18 July 2007

London: The Stationery Office

HC 838
£18.00

Contents

Foreword:

putting things right, sharing the lessons

In March this year, my Office celebrated the 40th anniversary of the establishment of the Parliamentary Ombudsman[1]. The Ombudsman post was created to put things right for people who have suffered from maladministration or poor service and to assist Parliament in calling Government to account. Since 1967, the public sector has changed almost beyond recognition and we have seen the introduction of legislation covering Freedom of Information, Data Protection and Human Rights. The role of Ombudsman itself has evolved with the times, but the principles behind its creation remain just as valid today.[2]

Everyone has the right to receive a good service from public bodies and to have things put right if they go wrong. To mark the 40th anniversary of my Office, I published the *Principles of Good Administration*.

The Principles are broad statements of what I believe bodies within the Ombudsman's jurisdiction should do to deliver good administration and customer service. Based on the considerable expertise and experience

[1] The Parliamentary Commissioner Act 1967 established the post of Parliamentary Commissioner for Administration.

[2] A specially commissioned paper, *The Parliamentary Ombudsman: Withstanding the test of time* (HC 421), published in March 2007 to commemorate the anniversary, charts the development of the Ombudsman role.

of my Office in handling large numbers of complaints over the past 40 years, the Principles show the sorts of behaviour we expect and the tests we apply when determining complaints. I am pleased that the Principles have been welcomed across Government and the NHS and hope that public bodies and policy makers will find them a useful contribution to improving public services.

"We think the principles represent common sense and good practice."

(Government response to Principles of Good Administration consultation)

"We note that many of the high profile cases which we have dealt with over the last year might have been avoided if [the Principles] had been applied."

(Public Administration Select Committee response to Principles of Good Administration consultation)

"The Principles are comprehensive and set out a useful framework of features that all users of public services would wish to see."

(Healthcare Commission)

Many complaints come to my Office because of a failure to follow the *Principles of Good Administration*. For example poor communication, misleading or incomplete information and a lack of transparency – in short, a lack of customer focus – are themes I encounter all too often. The effects on the people at the receiving end can be deeply distressing.

Ann Abraham
Parliamentary and Health Service Ombudsman

When things do go wrong it is best for complainants to have their complaint resolved at a local level, as the Principles suggest. Public bodies should handle complaints well at source and put things right promptly. A straightforward explanation of what went wrong can often prevent a complaint escalating beyond the point of local resolution. But, as one complainant remarked about a department, *"No one had the humanity to come out from behind the shield of bureaucratic doublespeak."* Many complaints I receive could, and should, have been resolved much earlier by the body concerned.

Making recommendations for remedying injustice is an important part of my Office's work. However, public bodies often lack a consistent approach to providing a fair and appropriate remedy for people who have suffered injustice. To coincide with the 40th anniversary I issued a consultation paper on draft *Principles for Remedy*, setting out how I believe public bodies should approach putting things right.

Complainants often express the wish that others will benefit from their complaint and remedying a single complaint can involve making wider changes to policies, procedures or systems. Public bodies should not only address individual complaints, but also fix underlying problems and translate the learning into better service for all. I believe the Ombudsman has an important role as a catalyst in this regard and contributing to service improvement is a strategic objective for my Office.

Principles of Good Administration

Good administration by a public body means:

1 Getting it right

- Acting in accordance with the law and with due regard for the rights of those concerned
- Acting in accordance with the public body's policy and guidance (published or internal)
- Taking proper account of established good practice
- Providing effective services, using appropriately trained and competent staff
- Taking reasonable decisions, based on all relevant considerations.

2 Being customer focused

- Ensuring people can access services easily
- Informing customers what they can expect and what the public body expects of them
- Keeping to its commitments, including any published service standards
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3 Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately
- Keeping proper and appropriate records
- Taking responsibility for its actions.

4 Acting fairly and proportionately

- Treating people impartially, with respect and courtesy
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests
- Dealing with people and issues objectively and consistently
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5 Putting things right

- Acknowledging mistakes and apologising where appropriate
- Putting mistakes right quickly and effectively
- Providing clear and timely information on how and when to appeal or complain
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6 Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective
- Asking for feedback and using it to improve services and performance
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

In the NHS, it is disappointing that there was little progress nationally this year towards improved complaints handling. However, I welcome the fact that complaint handling is now back on the agenda following the launch of the Department of Health's consultation document on integrating the handling of health and social care complaints, *Making Experiences Count: A new approach to responding to complaints* (June 2007). This integration was one of my recommendations in 2005 and my Office has had considerable input to the development of the proposals.

Nonetheless, if new arrangements are to be successful, the standard of complaints handling in the NHS must improve substantially. I share this conviction with the Healthcare Commission, whose role as regulator is a powerful lever for improvement. I recognise that NHS bodies juggle many priorities, but there is no excuse for the poor service complainants sometimes receive.

Where I have upheld a complaint, the body concerned normally accepts my findings and properly considers my recommendations for remedy. Unusually, despite support from the Public Administration Select Committee for my report on occupational pensions, *Trusting in the Pensions Promise* (March 2006), the Government largely rejected my findings and recommendations. Members of the Pensions Action Group subsequently initiated judicial review proceedings against the Department for Work and Pensions. The High Court judgment in February 2007 is now the subject of an appeal by the Secretary of State and a cross-appeal by the claimants. I have notified the parties of my intention to be an active participant in the appeal. I agree with the Secretary of State for Work and Pensions that this appeal raises, *"important legal and constitutional issues, in particular on the relationship between the Ombudsman and the Government."*

It would be unreasonable to expect bodies in my jurisdiction to adopt the *Principles of Good Administration* if my Office did not also apply them to every aspect of our work. The Ombudsman is the last resort for complainants: we have a duty to investigate thoroughly and promptly. We are committed to providing an excellent service and taking steps to improve it at every opportunity.

We have made good progress this year towards achieving our strategic goals. I would like to thank all my staff for making this possible and for their hard work at a time of continuing change. Looking ahead, there are new challenges to tackle and aspects of our work that we intend to improve upon, but I believe that my Office has withstood the test of time by not losing sight of its founding principles or the people we serve.

"It is reassuring to know that the Ombudsman is there for children and families like ourselves with genuine concerns that can be addressed and resolved."

(Mr A, complainant, HS-6311)

Ann Abraham
Parliamentary and Health Service Ombudsman

July 2007

"Everyone has the right to receive a good service from public bodies and to have things put right if they go wrong."

Government departments, agencies and public bodies

In 2006-07 we reported on 1,363 investigations relating to government departments, agencies and public bodies, of which 393 were about tax credits. A further 329 cases were accepted for investigation during the year but subsequently closed as an enquiry as a result of a change in our process for assessing requests to investigate (see the section 'Our workload and performance' for more details). Twenty-one cases were discontinued, mostly at the request of the complainant.

Figure 1
Parliamentary cases accepted and concluded in 2006-07

	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	In hand at 1.4.07
Parliamentary – tax credits	314	120	15	1	393	25
Parliamentary – other	828	700	314	20	970	224
Parliamentary total	**1,142**	**820**	**329**	**21**	**1,363**	**249**

† See 'Our workload and performance' for an explanation of the restatement of 1 April 2006 figures

Figure 1 summarises the method of closure for parliamentary cases, showing tax credits cases separately from other cases. A large proportion of our work over the past two years has involved complaints about tax credits. For this reason we have separated the number of complaints received on this subject from the general parliamentary complaints.

We fully or partly upheld 58% of the parliamentary cases we investigated, excluding those about tax credits. For tax credits, the uphold rate was higher (74% fully or partly upheld).

As in previous years, a small number of departments and agencies generated a large proportion of the complaints we investigated. They are generally those that have the highest number of contacts with the public. Figure 2 shows the five departments and agencies with the highest number of complaints reported on in 2006-07, with the uphold rate. These include the Department for Work and Pensions (DWP) (Figure 3 shows complaints against this Department and its agencies), HM Revenue and Customs (HMRC) and the former Immigration and Nationality

Directorate (IND, now the Border and Immigration Agency) of the Home Office. We have put considerable effort into supporting these departments in improving their complaints handling, since we consider that many of the complaints the Ombudsman receives could, and should, have been resolved more quickly and effectively at source.

There is a wide range of public bodies falling within the Ombudsman's jurisdiction.

Figure 4 on pages 9-12 lists the number of complaints against each body. Some of these bodies are small and not widely known and many of them have little direct contact with the public.

Figure 2
Highest number of Parliamentary complaints by body 2006-07

	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	% upheld	In hand at 1.4.07
HM Revenue and Customs – tax credits	314	120	15	1	393	74%	25
HM Revenue and Customs – other	103	47	26	3	106	33%	16
Jobcentre Plus	149	126	48	3	174	62%	50
Child Support Agency	180	68	40	3	174	82%	31
Immigration and Nationality Directorate	51	106	10	2	112	76%	33
The Pension Service	45	55	28	2	58	69%	12

† See 'Our workload and performance' for an explanation of the restatement of 1 April 2006 figures

Figure 3
Complaints against the Department for Work and Pensions and its agencies 2006-07

	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	% upheld	In hand at 1.4.07
Jobcentre Plus	149	126	48	3	174	62%	50
Child Support Agency	180	68	40	3	174	82%	31
The Pension Service	45	55	28	2	58	69%	12
Disability and Carers Service	38	36	19	0	48	52%	7
Debt Management Unit	14	13	3	2	15	60%	7
Department for Work and Pensions	17	4	4	1	13	69%	3
Health and Safety Executive	3	3	1	0	3	33%	2
Rent Service	1	3	3	0	1	0%	0

† See 'Our workload and performance' for an explanation of the restatement of 1 April 2006 figures

Figure 4
Parliamentary complaints by body complained about

	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	% upheld	In hand at 1.4.07
Asylum and Immigration Tribunal	0	3	0	0	3	33%	0
Cabinet Office	0	1	1	0	0	–	0
Charity Commission	4	1	2	0	2	100%	1
Charter Mark Unit	0	1	1	0	0	–	0
Child Benefit Office	0	2	0	0	0	–	2
Child Support Agency	180	68	40	3	174	82%	31
Children and Family Court Advisory and Support Service	7	6	7	0	5	80%	1
Coal Authority	1	0	0	0	0	–	1
Commission for Patient and Public Involvement in Health	0	1	0	0	1	100%	0
Commission for Social Care Inspection	14	2	1	0	14	50%	1
Companies House	0	1	0	0	1	0%	0
Compensation Agency	1	1	1	0	1	0%	0
Construction Industry Training Board	1	0	0	0	1	0%	0
Consumer Council for Water	0	1	1	0	0	–	0
Criminal Injuries Compensation Appeals Panel	1	5	2	0	3	0%	1
Criminal Injuries Compensation Authority	6	6	1	0	10	30%	1
Criminal Records Bureau	16	18	0	0	28	93%	6
Crown Estate Office	1	1	1	0	1	0%	0
Crown Prosecution Service*	0	2	2	0	0	–	0
Debt Management Unit	14	13	3	2	15	60%	7
Department for Communities and Local Government	2	1	0	0	1	0%	2
Department for Constitutional Affairs	6	1	2	0	4	25%	1
Department for Culture, Media and Sport	0	1	0	0	1	0%	0
Department for Education and Skills	5	5	3	0	7	43%	0
Department for Environment, Food and Rural Affairs	11	13	1	0	18	28%	5
Department for Transport	1	0	0	0	1	0%	0

Figure 4
Parliamentary complaints by body complained about (continued)

	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	% upheld	In hand at 1.4.07
Department for Work and Pensions	17	4	4	1	13	69%	3
Department of Health	4	2	0	0	6	33%	0
Department of Trade and Industry	8	2	4	0	5	40%	1
Disability and Carers Service	38	36	19	0	48	52%	7
Driver & Vehicle Licensing Agency	5	16	9	0	12	33%	0
Driving Standards Agency	0	5	4	0	1	0%	0
Employment Appeal Tribunal	1	2	1	0	2	0%	0
Employment Tribunals Service	1	1	0	0	2	0%	0
English Heritage	0	1	0	0	0	–	1
English Partnerships	0	1	1	0	0	–	0
English Sports Council	2	0	0	0	0	–	2
Environment Agency	5	2	0	0	4	50%	3
Food Standards Agency	2	0	0	0	2	50%	0
Foreign and Commonwealth Office	12	8	6	1	8	50%	5
General Social Care Council	3	2	1	0	3	0%	1
Government Office for London	0	1	1	0	0	–	0
Government Office for the East of England	1	0	0	0	1	100%	0
Health and Safety Executive	3	3	1	0	3	33%	2
Healthcare Commission	4	0	0	0	4	50%	0
Highways Agency	5	9	2	0	10	40%	2
Historic Royal Palaces	0	1	0	0	1	0%	0
HM Courts Service	25	25	5	1	28	43%	16
HM Prison Service	1	6	1	1	2	0%	3
HM Revenue and Customs	417	167	41	4	499	65%	40
HM Treasury	1	1	0	0	0	-	2
Home Office	6	0	3	0	2	50%	1
Housing Corporation	0	1	0	0	1	0%	0
Identity and Passport Service	2	7	2	0	6	50%	1

Figure 4
Parliamentary complaints by body complained about (continued)

	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	% upheld	In hand at 1.4.07
Immigration and Nationality Directorate	51	106	10	2	112	76%	33
Independent Case Examiner	2	8	0	0	2	0%	8
Information Commissioner	4	3	0	0	6	17%	1
Insolvency Service	5	0	0	0	5	20%	0
Jobcentre Plus	149	126	48	3	174	62%	50
Land Registry	3	6	3	0	5	20%	1
Learning and Skills Council for England	1	1	1	0	1	100%	0
Legal Services Commission	29	14	13	0	26	58%	4
Ministry of Defence	1	2	0	0	3	33%	0
National Endowment for Science, Technology and the Arts	1	1	1	0	0	–	1
National Institute for Clinical Excellence	1	0	0	0	1	100%	0
National Insurance Contributions Office	5	9	2	0	10	30%	2
National Probation Service	0	1	0	0	0	–	1
Natural England	1	1	0	0	2	0%	0
Northern Ireland Court Service	1	0	0	0	1	100%	0
Northern Ireland Office	0	1	1	0	0	–	0
Office for National Statistics	0	1	0	0	1	100%	0
Office for Standards in Education (OFSTED)	3	2	4	0	1	100%	0
Office of Communications	0	1	1	0	0	–	0
Office of Fair Trading	0	1	0	0	1	0%	0
Office of Social Security and Child Support Commissioners	0	1	1	0	0	–	0
Office of the Director General of Water Services (OFWAT)	1	2	2	0	1	0%	0
Office of the Immigration Services Commissioner	1	0	0	0	1	0%	0
Parole Board	1	0	1	0	0	–	0
Pensions Ombudsman	1	2	3	0	0	–	0
Planning Inspectorate	5	5	4	0	6	33%	0

Figure 4
Parliamentary complaints by body complained about (continued)

	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	% upheld	In hand at 1.4.07
Police*	0	3	2	1	0	–	0
Postal Services Commission	0	1	1	0	0	–	0
Postwatch	1	0	0	0	1	0%	0
Prisons and Probation Ombudsman	1	6	1	0	6	17%	0
Public Guardianship Office	11	1	2	0	10	50%	0
Public Trust Office	1	0	0	0	1	0%	0
Regional Development Agencies	2	0	1	0	1	100%	0
Rent Service	1	3	3	0	1	0%	0
Residential Property Tribunal Service	1	1	1	1	0	–	0
Rural Payments Agency	8	16	8	1	10	80%	5
Security Industry Authority	0	5	0	0	3	67%	2
Special Educational Needs & Disability Tribunal	1	1	2	0	0	–	0
Standards Board for England	5	4	7	0	0	–	2
The Pension Service	45	55	28	2	58	69%	12
Training Organisation for the Personal Social Services	1	0	1	0	0	–	0
Tribunal Service	17	17	17	0	15	40%	2
UK Visas	6	7	4	1	6	100%	2
Valuation Office Agency	10	4	3	0	10	60%	1
Vehicle and Operator Service Agency	1	0	0	0	1	0%	0
Veterans Agency	6	3	1	0	7	43%	1
Total	**1,218**	**878**	**351**	**24**	**1,443**	**63%**	**278**

* All Crown Prosecution Service (CPS) and Police complaints refer to complaints made under the Victims' Code, see page 13
† See 'Our workload and performance' for an explanation of the restatement of 1 April 2006 figures

Victims' Code

This was the first year of the Victims' Code (the Code). The Code sets minimum standards of service that criminal justice agencies should provide to victims of crime. The Ombudsman considers complaints which criminal justice agencies have not resolved locally. During this first year, we investigated only one of the eight enquiries referred to us. The other enquiries concerned matters that either pre-dated the Code, or which are not subject to it, for example a prosecution decision or a police investigation. The Code has been in operation for only a short time and we lack any firm evidence to suggest why the volume of complaints has not been as high as we anticipated. It might be that victims are choosing to delay making a complaint until a prosecution has been concluded, which can be a lengthy process. It might also be that complainants find the complaints process itself confusing. This is an area we will continue to monitor from the complaints referred to us.

The section entitled 'Our Workload and Performance' provides further details of our work on Parliamentary enquiries and investigations.

The relevance of the Principles of Good Administration

We issued the *Principles of Good Administration* (the Principles) to help public bodies get it right and deal properly with their customers. The Principles are:

- **Getting it right**
- **Being customer focused**

- **Being open and accountable**
- **Acting fairly and proportionately**
- **Putting things right**
- **Seeking continuous improvement**

Recurring themes from the complaints we have investigated this year demonstrate the relevance of the Principles. Below we provide examples of how they apply to some of our complaints.

Getting it right

Government departments and agencies have millions of contacts with the public every year. Inevitably, mistakes sometimes occur and some customers are dissatisfied with a decision or the standard of service they have received. In some cases, we do not find any evidence of maladministration. In others, we find the misapplication of policies or procedures, or a failure to provide an effective service.

A number of complaints have arisen this year about failure to follow stated policies and procedures or about the application of contradictory guidance. A case involving the DWP showed that guidance on investigating benefit fraud was confusing.

DWP and HMRC regularly exchange information to assist them in preventing and detecting benefit fraud. DWP check this information to see whether people claiming income-based benefits appear to have more savings than they have declared and, if so, whether that affects their benefit entitlement. If there is evidence of this, Jobcentre Plus (on DWP's behalf) can interview a person under caution, if it appears that they might proceed to prosecute him or her later on. In this case, we found that Jobcentre Plus should have made informal enquiries first before proceeding to conduct formal interviews (see the case of Miss Y overleaf).

Case study
Ref. PA-8232

Confusing guidance on investigating possible benefit fraud

Miss Y claimed contribution-based Jobseeker's Allowance in November 2003. In March 2004, she began part-time self-employment and declared her earnings to Jobcentre Plus. In April she claimed income-based jobseeker's allowance. She told Jobcentre Plus that she had savings of £1,857. That summer her business took off and on 28 September, she told Jobcentre Plus of her intentions to end her benefit claim.

Meanwhile, in August 2004, Jobcentre Plus received information from the Revenue that Miss Y had savings in 2001-02, which, if she still had them, would put her above the limit for receipt of income-based jobseeker's allowance in May 2004. At that time she had received approximately £200 in income-based benefits. Jobcentre Plus decided to interview Miss Y under caution about her savings and she was invited to attend an interview on 24 September. Miss Y attended the interview, which was adjourned to allow her to collect information about her savings to bring to an interview a week later. Miss Y took her own life on 29 September 2004. Two DWP officers have indicated that sanction action would have been unlikely in Miss Y's case even if it had been found that she had wrongly received benefits.

Miss Y's mother complained about Jobcentre Plus's actions, believing they incorrectly used information about her savings and inappropriately interviewed her under caution, which led to her taking her own life.

We partly upheld the complaint. We found that:

- Jobcentre Plus were maladministrative in the way they decided to interview Miss Y under caution;
- Miss Y had insufficient time to prepare for the interview;
- parts of the procedures for investigating undeclared savings were confusing and contradictory – guidance tells Jobcentre Plus investigators to treat HMRC's savings data with caution, but goes on to say that, where there are grounds to suspect an offence on the basis of that data, claimants should be processed for an interview under caution.

On the balance of probabilities, we did not uphold the complaint that the interview under caution directly caused Miss Y to take her life, although we recognised her parents were clearly very distressed and believed this to be the case.

Jobcentre Plus agreed to our recommendation that they should review their procedures for dealing with HMRC's savings data. They have strengthened the requirement to consider all available evidence and the likelihood of prosecution before proceeding to interview under caution.

Being customer focused

Delays in dealing with correspondence, claims or applications are among the most common failings we encounter - a clear sign that a public body is not being customer focused. We reported on 112 complaints this year about the former IND of the Home Office (now the Border and Immigration Agency). Many of these related to delays in handling applications combined with administrative errors that prolonged the delay (see the case of Mr P opposite). The uphold rate of 76% for IND cases is higher than that for parliamentary cases overall (58%, excluding tax credits complaints). We have had constructive discussions with IND about complaints handling during the year. More details are on page 18.

Delay has also been the subject of a number of complaints about the Rural Payments Agency's handling of farmers' claims under the 2005 Single Payments Scheme. The scheme replaced the 11 subsidies paid to farmers based on agricultural production with one payment for land management. Twenty-four of these

Case study
Ref. PA-16220

Mishandling of an application for asylum

Mr P complained in 2006 that his asylum application, made in November 1998, remained unresolved.

Mr P arrived in the UK on 9 November 1998 and applied for asylum. On 18 October 1999 he was granted exceptional leave to remain in the UK for one year, without consideration being given to his asylum application in accordance with IND's then policy on the former Federal Republic of Yugoslavia. On 1 November 2000, Mr P's solicitors wrote to IND asking about his application's progress. IND interviewed Mr P on 25 January 2001. His asylum application was refused on the same day, but the letter setting out the full reasons for refusal and the appeal papers were never sent. IND have been unable to explain why this occurred, but have attributed it to a processing error.

Following this, Mr P's file was moved around within IND and, despite letters from Mr P's MP and solicitors, no action was taken on his application. Neither did his solicitors receive replies to their letters. Finally, in late 2005, IND withdrew the decision of 25 January 2001 but took no further action and failed to inform Mr P's solicitors, although they later confirmed the decision to Mr P's MP and said that an asylum team was dealing with his case.

In August 2006, IND wrote to Mr P removing his permission to work, but reinstated it promptly following a letter from Mr P's MP and the Ombudsman's intervention asking them to do so.

We found that IND's handling of Mr P's application was exceptionally poor and we upheld his complaint. His file had been unnecessarily moved around the Directorate and incorrectly placed in holding areas. IND failed to take a number of opportunities to rectify the situation, even though in the later stages they were aware of their failure to serve the refusal of asylum decision on Mr P. They consistently failed to inform Mr P or his solicitors of the current status of his application.

IND acknowledged that they had handled Mr P's case poorly. To remedy matters they agreed to:

- invite Mr P to an interview to give him the opportunity to put forward any additional information before making a decision on his application;
- apologise to Mr P, his solicitors and his MP for their poor handling and the avoidable delay in resolving his application;
- award Mr P a consolatory payment of £250 in recognition of the distress and inconvenience he had suffered.

complaints fell into two broad categories and two representative cases are under investigation, which we aim to complete in 2007-08. These involve:

- complaints about the length of time it took the Rural Payments Agency to provide farmers and landowners with accurate digitised maps of their fields. Complainants told us that errors were reported and corrected, only for fresh mistakes to appear;
- complaints about notifying farmers and landowners of their scheme entitlement and delay in making the payments. Complainants told us that this had caused them financial loss, including increased interest payments and banking charges, inconvenience and stress.

Being open and accountable

One of the Principles stipulates that public bodies should always be open and accountable. That includes ensuring that information, and any advice provided, is clear, accurate and complete. Some complainants have received poor advice or have been influenced by misleading information to make decisions that they would not otherwise have made. Through no fault of their own, they have experienced considerable distress and sometimes financial loss. The complaint of Mrs A against The Pension Service of DWP illustrates this.

Misleading information has also been the subject of a number of complaints we have investigated this year against the Criminal Records Bureau (the Bureau). We reported on 28 complaints, of which all but two were upheld. The majority were about delays in processing Enhanced

Case study
Ref. PA-7809

Provision of inadequate information

Mrs A complained that an officer at The Pension Service had given her inadequate information by failing to tell her that if she remarried before her 60th birthday, she would lose her right to use her ex-husband's National Insurance contributions. Mrs A remarried six weeks before reaching retirement age and received a reduced rate retirement pension based only on her own contributions. She said that, if she had been given complete information about the consequences of her remarriage for her pension, she would have postponed her marriage until after she had reached age 60. Mrs A also complained that The Pension Service failed to send her a pension forecast. Combined with the inadequate information from The Pension Service, this led to the loss of almost half the weekly retirement pension she would otherwise have been entitled to.

We upheld Mrs A's complaint on the basis that:

- The Pension Service failed to provide the pension forecast and adequate information which resulted in Mrs A not receiving the advice she needed to make a reasonable decision about when she should get married and what the consequences would be;
- that these failures contributed directly to Mrs A's loss of entitlement to her full retirement pension.

The Pension Service agreed to pay Mrs A £7,264.91 for the pension she should have received for the period 27 January 2003 to 5 November 2005. They also agreed to pay £526.04 in recognition of the loss of the use of the money and an ongoing payment of £38.75 per week in addition to the normal payment of her state pension. This put Mrs A back in the position she would have been in, but for the maladministration.

Mrs A wrote to us and said,

"It is a tremendous relief to have the matter settled in my favour. As you can imagine the last few years have been very difficult and worrying".

Disclosures which are required for posts involving a high level of contact with children or vulnerable adults, for example teachers or carers. This certifies that there is no evidence of a criminal record or other information that would bar them from doing such work.

The Bureau provides a one stop shop for applications for Enhanced Disclosures. In many cases, the delays were caused by staff shortages and other problems which delayed police checking of applications, and were therefore not directly within the Bureau's control. However, the Bureau was fully aware of these problems and did not warn applicants of the likelihood of delay. We therefore upheld the complaints because the Bureau's escalation process misled applicants about how long they would have to wait for a Disclosure. The Bureau agreed to compensate complainants whose case was upheld for loss of earnings or inconvenience, since they had failed to manage complainants' expectations of the service they would receive and the likely timescale for the issue of Disclosures. See the case of Mr J opposite.

Case study
Ref. PA-11768

Delay in processing an application for Enhanced Disclosure

Mr J, an Ofsted inspector, complained that the Criminal Records Bureau delayed in processing his application for Enhanced Disclosure. As a result, he had to withdraw from three Ofsted inspections, causing financial loss.

It took the Bureau just over eight weeks to process Mr J's application. During that time, the Bureau failed to alert Mr J to the likely delay when his application was with the police for checking. The Bureau's published service standard for the processing of enhanced applications is 90% within four weeks, but they have a published agreement with the police to pursue matters with them after eight weeks if their checks on an application remain outstanding. We considered it reasonable for Mr J to expect that he would receive his Disclosure within the Bureau's four week published service standard.

We recommended the Bureau should compensate Mr J for loss of earnings and make him a consolatory payment in recognition of the inconvenience caused.

The Bureau agreed that they had mismanaged Mr J's expectations. They consequently agreed to make him a payment of £4,000: £3,870 for loss of earnings and £130 as a consolatory payment for the inconvenience caused.

Putting things right

Departments and agencies with a high public profile and many customer contacts are bound to generate complaints about decisions and processes. This makes it even more important that they handle complaints well at source. Those bodies which do not operate an effective complaints procedure are failing to act up to the Principles. The high uphold rates for complaints we investigate about some of these departments show that there is still room for improvement. An example of the need to put mistakes right, quickly, is the case of Mrs X (opposite).

Senior staff from this Office have held regular liaison meetings with the Director General of IND (now the Chief Executive of its successor body, the Border and Immigration Agency). We agreed to establish a direct route into IND, for resolving some complaints without carrying out a full investigation, which had not previously existed. In this way, we have quickly resolved complaints on several occasions during the year.

Assisting government departments and agencies in making improvements to their complaints handling is a priority for us. During the year we had productive discussions with Ministers and staff at DWP. In October 2006 the Ombudsman and some of her investigation staff hosted a visit to the Office by the Rt Hon John Hutton MP, Secretary of State for Work and Pensions. This gave the Secretary of State the opportunity to learn about our day-to-day work, the types of issues that cases about DWP raise and the effect on complainants. The Ombudsman and senior staff also met DWP's Executive Team in November 2006 to discuss opportunities to improve complaints handling across the department.

Case study
Ref. PA-13448

Inadequate handling of an application

Advisers complained on behalf of Mrs X about the way in which the Immigration and Nationality Directorate (IND) had handled her application for leave to remain in the UK.

It took IND two years to determine Mrs X's application for leave to remain in the UK as a domestic worker in a private household, which she made on 23 May 2003. Although IND wrote to Mrs X in June 2003 indicating that they expected to determine her application by March 2004, it was not until June 2005 that this occurred. IND then repeatedly gave Mrs X leave to remain in a diplomatic household rather than a private household and it took them almost a year to correct that error. Following the lengthy intervention of Mrs X's advisers and Mrs X's MP, IND finally issued Mrs X's correctly endorsed passport and status documents on 11 April 2006.

We upheld the advisers' complaint. It was clear that there was a series of errors and delays by IND in their handling of the case. The advisers wrote to IND's complaints unit on four occasions, but IND acknowledged only some of those letters and never provided a substantive response to the complaints.

IND acknowledged that their handling of Mrs X's application was unacceptable. They awarded her a consolatory payment of £100 for the inconvenience caused. They also apologised to her advisers for the poor handling of their complaints.

There have been a number of promising developments at DWP. The Department extended the remit of the second-tier Independent Case Examiner to cover all of its businesses from 1 April 2007[3], a move we have advocated for some time. In addition, the Child Support Agency (the Agency), whose complaints handling has left much to be desired in the past (see Miss G's case opposite), overhauled their internal complaints process with effect from April 2007. There is now a two-stage process within the Agency, staffed by a team of dedicated complaints handlers. If a complaint is not resolved through that process, a complainant can approach the Independent Case Examiner and then, if necessary, the Ombudsman via his or her MP. All of these new arrangements are at an early stage, but we hope they will provide a speedier and more satisfactory route to resolution for DWP complainants.

"We will publish the fact that we will adhere to these principles, so that people can judge our service against them where appropriate."

(Independent Case Examiner, DWP, response to the Principles consultation.)

[3] Jobcentre Plus, The Pension Service, the Child Support Agency, the Disability and Carers Service, Debt Management, The Rent Service and the Financial Assistance Scheme.

Case study
Ref. PA-7361

Persistent errors and poor complaint handling

Miss G is a parent who is responsible for childcare. She complained about the general handling of her case by the Child Support Agency (the Agency). Specifically, she said they failed to set the correct effective date (from which maintenance would be payable) on her case and that she had not received child support maintenance as a result.

Miss G completed a maintenance application form in February 1999. Following receipt of that form, the Agency sent the non-resident parent a maintenance enquiry form. However, the non-resident parent failed to return it and the Agency sent a duplicate form in July 2000. The non-resident parent again failed to return the form, but the Agency failed to take appropriate action to collect the relevant information. The Agency changed the effective date several times but failed to deal with the issue of financial loss that Miss G had suffered.

When she complained to the Ombudsman, Miss G believed that the Agency had set the effective date later than they should have done and failed to explain their actions. The Agency failed initially to respond to our enquiries. This led to significant and unnecessary delays in processing the

investigation. Achieving a successful resolution required senior staff at the Agency to follow matters up at our request.

We fully upheld Miss G's complaint. We were very critical of the Agency for their handling of Miss G's case both before and after its referral to the Ombudsman.

Eventually, the Agency took positive action to make amends by making a payment of £4,792.29 plus interest in respect of maintenance that Miss G should have received, and £85 in consolatory payments to Miss G.

Putting things right: tax credits

Our special report, *Tax credits: putting things right* (HC 124, June 2005), highlighted extensive problems with the delivery and operation of the tax credits system following its introduction in April 2003. The report raised concerns about the way in which HMRC handled the recovery of overpayments which were a result of HMRC's own mistakes. These mistakes caused financial hardship and distress to some families with children, and others on low incomes (see the case of Mrs A overleaf). We received many complaints about this, a large proportion of which could, and should, have been resolved satisfactorily by the Tax Credit Office.

Following constructive discussions with this Office, HMRC made changes to the way they handle complaints about tax credits. We were satisfied that these changes should see a reduction in the backlog of complaints at HMRC and complainants should receive a better and more prompt response from them. It was agreed with the Tax Credit Office and the Adjudicator's Office that the changes would be implemented from 1 April 2006. We now only investigate complaints which have exhausted HMRC's complaints procedures, raise new issues which we feel need exploring, or where there are other issues which make a referral to the Tax Credit Office or the Adjudicator's Office inappropriate. We refer all other cases back to those Offices for investigation and resolution. Both Offices have established a central team to deal with these complaints and to ensure that they are handled promptly and appropriately.

As a result, we accepted fewer cases for investigation in 2006-07 than in the previous year (120 compared with 404). During the year we reported on 393 cases, some of which had been accepted in previous years. We referred 330 complaints back to the Tax Credit Office and the Adjudicator's Office under the new arrangements. (See Figures 1 and 2 on pages 7 and 8 and the section on 'Our Workload and Performance').

The proportion of tax credit cases fully or partly upheld has also been reduced from the previous year (74% compared with 90%). It would appear the reduction in complaints referred to us is a result of administrative improvements in the tax credit system. The complaints we receive about not getting through to their helpline, being given inappropriate advice or not receiving a response have declined in number. As a result, the majority of complaints are now about overpayments.

As a large number of complaints about tax credits continue to be referred to us, and constitute a significant proportion of our parliamentary work, we plan to issue a follow-up report on tax credits in 2007-08.

Case study
Ref. PA-17355

Overpayment of tax credits

Mrs A complained in January 2005 that her tax credits payments stopped without warning. This occurred shortly after she had informed HMRC that she was receiving less tax credits than she was entitled to because they had not registered her daughter as being in full-time education. She was told there was a major system error that could not be repaired and she eventually started to receive manual payments. After informing HMRC that she had received three renewal notices, all of which were incorrect, she received an award notice that took no account of her daughter being in full-time education. Mrs A immediately reported this, but HMRC then paid two payments totalling £2,579.14 into her bank account. Mrs A suspected these were gross overpayments, but she had no idea by that point what her real entitlement was.

HMRC accepted that there had been an overpayment, but told Mrs A they would write to her once they had worked out how much she owed them. However, they failed to do so. Instead, they started making deductions from her payments. Mrs A then received three further award notices, each of which referred to a different level of overpayment. Furthermore, the amount she owed increased as time passed, but HMRC never explained the reason for this.

Mrs A said that her health had suffered as a direct result of the stress and anxiety caused by dealing with HMRC.

We found that the system fault, combined with a series of complex errors, meant that Mrs A could not reasonably have been expected to work out whether the payments she was receiving bore any relation to her actual entitlement.

HMRC agreed to waive the overpayments which totalled £3,676.01, paid Mrs A, a lump sum of £492.56 (the sum they had already recovered from her) and made her a consolatory payment of £160 for the inconvenience and distress their errors had caused.

The draft *Principles for Remedy*, which we issued for consultation in March 2007, provide a framework for putting things right. Many of the departments and agencies we deal with already have internal guidelines for calculating financial redress payments (see the case of Mr D overleaf). However, a proper approach to remedy is about much more than financial redress, which is only one of a range of possible responses. It is also about the way in which people are treated and how the lessons are used to improve customer service or administrative practice. Our investigations reveal the lack of a consistent approach to redress and remedy across departments and agencies.

Seeking continuous improvement

The *Principles of Good Administration* make clear the importance of addressing the underlying problems that lead to complaints in order to avoid similar difficulties for others. For that reason, we may recommend the review and amendment of guidelines or procedures, or additional staff training, to address wider problems. The case of Mr A overleaf shows how a complaint can help to improve services.

Case study
Ref. PA-6339

Backdating of a war disablement pension

Mr D complained that the Veterans Agency (the Agency), having agreed in 1995 to backdate the award of his war pension to 1957, had refused to pay interest on that payment. As a result, Mr D suffered financial loss.

The war pension scheme applies to former members of the armed forces who have suffered disablement due to injury or disease attributable to their service. The degree of disability compared with a healthy person is expressed in percentage terms. A one-off gratuity is paid for disability assessed at less than 20%; disability assessed at 20% or more is paid as an ongoing war pension. If claims are made outside certain time limits, the start date for the award is the date of the claim. Until 7 April 1997, the Secretary of State for Defence had discretion to depart from this rule where it was considered reasonable to do so and substantial evidence could be produced to support the decision.

Mr D was discharged from his National Service on medical grounds in January 1957. Although the Ministry of Defence sent Mr D's medical records to the Agency for them to consider if a pension should be paid, the available records do not show what decision the Agency took. Mr D said the Agency had no contact with him at that time.

In September 1993, having learned that he might qualify, Mr D applied for a war pension. His file could not be found and the Agency said that it appeared to have been destroyed during a file weeding exercise in 1989. This should not have happened, since Mr D's circumstances in 1989 had not met the criteria for file destruction.

Initially, the Agency awarded Mr D a gratuity. Having considered further medical evidence supplied by Mr D, they then awarded a war pension from the date of Mr D's claim in September 1993. Mr D made further representations about the start date and the Agency agreed in May 2005, to backdate it to January 1957. They paid him a lump sum back-payment of £23,806.14, covering the period from January 1957 to September 1993. Mr D and his solicitors subsequently sought interest on the backdated payment. The Agency consistently refused these requests. They did not accept there was evidence of clear and unambiguous error and said that the decision to backdate had been made in 'good faith' and was not an admission of error.

We considered there had been maladministration in 1957 and in 1989, when Mr D's file was destroyed. The absence of the file means it is not possible to know what happened in 1957. However, we saw the decision to backdate the

payments in 1995 as an admission of error and we therefore concluded that since the Agency had decided that he was due a pension from 1957 they should pay interest.

The Agency agreed to pay Mr D the outstanding interest and interest on that interest up to the end of August 2006. In accordance with the Agency's financial redress scheme, the interest on the backdated award came to £26,745.18 and the interest on that interest to £12,104.92, a total of £38,850.10.

Case study
Ref. PA-5916

Change in guidance following a complaint

Mr A, a pensioner, remarried in 2002. He saw a Pension Service leaflet, which said he must inform them of changes in circumstances. He contacted The Pension Service and was told to send in his marriage certificate, but received no further advice or assistance. They also wrote to him telling him to send the certificate in, but again did not give any further advice. Mr A did so, but heard nothing more. He assumed that his benefit would not be affected by his remarriage, as The Pension Service had not raised this with him.

In 2004 Mr A spoke to The Pension Service about his wife's pension. They told him he could have applied for adult dependency increase in 2002. Mr A made an immediate claim, and attempted to backdate it. The Pension Service backdated it for the maximum three months, and Mr A appealed to the Tribunal. The Tribunal dismissed his appeal, but highlighted the fact that The Pension Service had not provided any advice in 2002. Mr A made three requests for compensation, all of which were refused. He then complained to the Ombudsman.

We found that The Pension Service had failed to provide advice and the Pensions Procedure Guide (the Guide) failed to provide adequate guidance to staff on this issue. Mr A had been acting on a Pension Service leaflet, which told him he had to inform The Pension Service of a change of circumstances, which could affect his entitlement. Mr A should therefore have expected assistance when he contacted them in 2002.

The Pension Service initially rejected this approach. They said it was Mr A's responsibility to ensure he was getting all the benefit he was entitled to. However, they agreed to amend the Guide to ensure that in the future people in a similar situation would get more assistance. But The Pension Service said that at the time Mr A had called, the guidance was adequate and they had not provided a substandard service.

We referred The Pension Service to their Service Standards Framework document, which was approved in early 2002. This said that DWP staff should *'provide a proactive service...such as explaining options, identifying further action...and giving assistance'*. The Pensions Service then agreed that the procedures in place in 2002 failed to uphold these standards, and were therefore maladministrative.

As a result, Mr A received £4,204.40 (plus interest) in compensation for lost adult dependency increase and a £200 consolatory award.

The Pension Service have agreed to review and amend the Guide in line with the recommendations in our report, which include explaining potential options and giving general advice to people who had made a proactive attempt to inform them of a change in circumstances.

Ex gratia compensation schemes

During the year we published a special report, *Put together in haste: 'Cod Wars' trawlermen's compensation scheme* (HC 313, February 2007), which reported on our investigation into complaints about the Icelandic waters trawlermen's compensation scheme.

The Department of Trade and Industry (DTI) set up the ex gratia scheme in 2000 to compensate former UK-based Icelandic waters trawlermen who had lost their livelihoods as a result of the settling of the 'Cod Wars' with Iceland in the 1970s.

We found that there were shortcomings in the way that the scheme was devised, announced and operated.

DTI agreed to our recommendations and undertook to:

- make a consolatory payment of £1,000 to each of the five complainants;
- review the eligibility criteria and scheme rules to ensure that they are consistent with the policy intention behind the scheme;
- once the review is complete, reconsider the cases of the five complainants in line with the outcome of the review;
- consider the case of anyone else who claims to have suffered a similar injustice.

We had already made similar findings in *A Debt of Honour: the ex gratia scheme for British groups interned by the Japanese during the Second World War* (HC 324, July 2005), a report on our investigation into complaints about the Ministry of Defence (MoD) compensation scheme.

There were such similar issues in both cases that, in addition to the four recommendations in the trawlermen report, we made a fifth recommendation: that the Government should develop central guidance for public bodies on the development and operation of ex gratia compensation schemes.

The Ombudsman said, *"Such guidance can, in my view, only be helpful to [public bodies] – and may well prevent a reoccurrence of the problems I have identified in this report."* The Government has accepted the need for such guidance. HM Treasury have indicated that this work will be incorporated into the revision of its manual Government Accounting, which is due for publication during this year.

We are also pleased that the Government has now fully accepted the recommendations made in *A Debt of Honour*. The MoD commissioned its own report into the administration of the scheme and accepted that errors had been made. On 14 March 2007, the Veterans Minister announced that he had placed a copy of the MoD's detailed response to the report into how inconsistent criteria came to be used in deciding payments to former civilian internees in the House of Commons Library. The Minister said that the report's recommendations were all being considered and that some of them were being taken into account as part of a wider review of the MoD's guidance on policy making.

In reviewing the scheme the MoD consulted the representative organisation for civilian internees, the Association of British Civilian Internees (Far East Region), and the Ombudsman to ensure that their views were taken into account. The extension of the scheme in June 2006,

to include those who were British subjects when interned and who had lived in the UK for 20 years, between 1945 and 2000, went some way towards putting things right. The further full reconsideration of the cases of those denied a payment under the earlier scheme criteria resulted in further awards to some former internees.

The Public Administration Select Committee took evidence from the Minister for Veterans on 25 January 2007. The Chairman concluded that the story was not yet over and urged the Minister to try to sort out the remaining unfairness in the ex gratia compensation scheme.

Occupational pensions

Our report *Trusting in the pensions promise: government bodies and the security of final salary occupational pensions* (HC 984, March 2006) found that official information provided over many years gave a misleading impression of the security of occupational pensions schemes. This caused injustice to a large number of people who complained that they had relied on government information when making choices about their future pension provision. Many of these people lost all or most of their pension when their occupational pension schemes were wound up.

A report by the Public Administration Select Committee in July 2006[4] supported our findings of maladministration and argued that: *"the Government cannot simply abandon people who have lost significant sums of money. It should work with others who share responsibility to find a solution.*[5]*"*

The Secretary of State for Work and Pensions rejected the findings of fact and all but one of the recommendations in our report.

Following the Secretary of State's decision, four members of the Pensions Action Group (representing members of failed final salary occupational pension schemes) initiated a claim for a judicial review against the DWP.

Mr Justice Bean handed down his judgment in the High Court of Justice (the Court) on 21 February 2007. The most significant elements of the judgment were that:

- the Court quashed the decision of the Secretary of State to reject the Ombudsman's findings that official information on the security of pensions was misleading;
- the Court directed the Secretary of State to reconsider the recommendation that the Government should consider making arrangements for pension restoration in the light of the finding that the misleading official information constituted maladministration;
- the Court ruled that, unless the findings made in one of the Ombudsman's reports are *"objectively shown to be flawed or irrational, or peripheral, or there is genuine fresh evidence to be considered"*, those findings are binding on the parties to complaints.

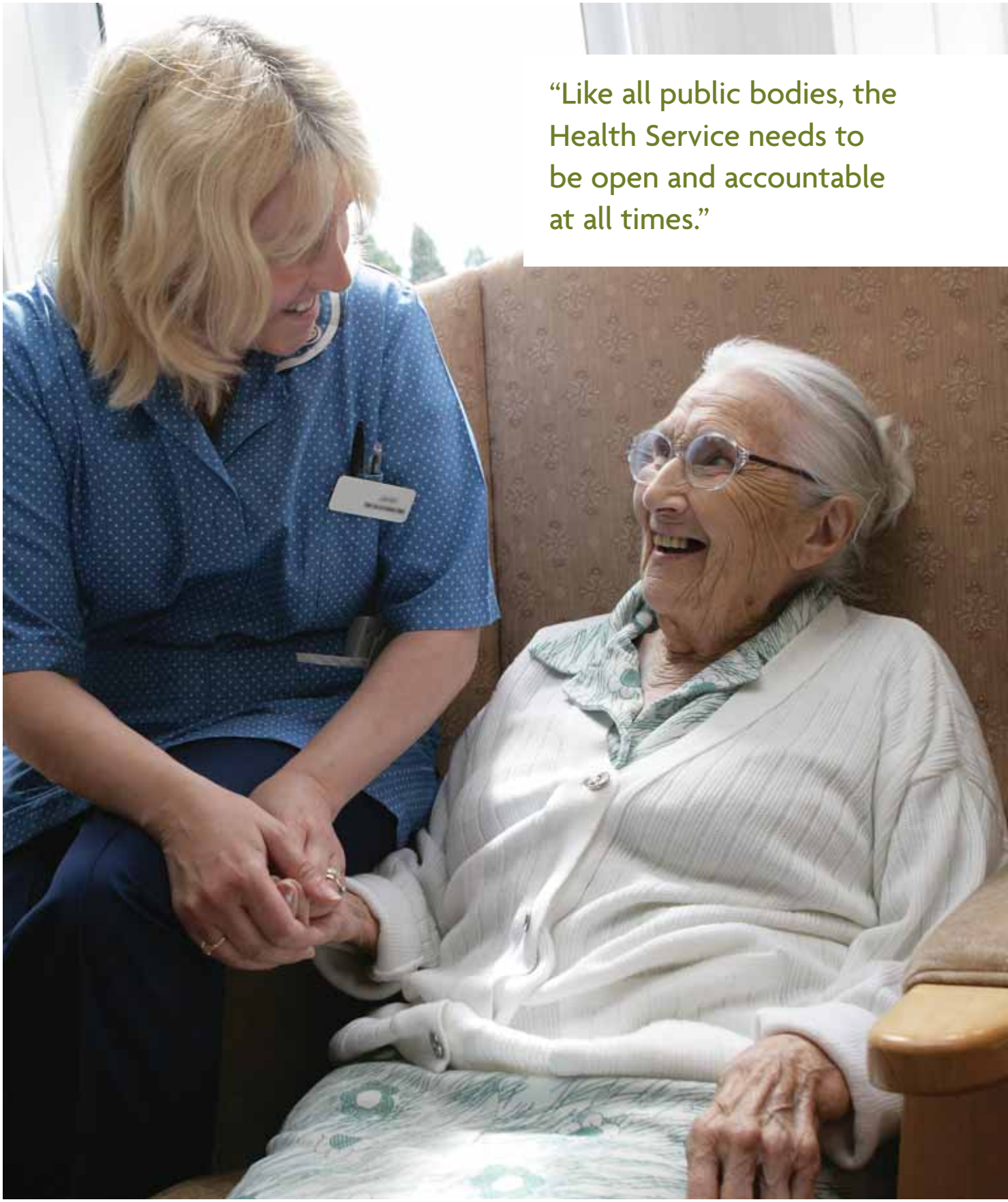
The judgment is the subject of an appeal by the Secretary of State for Work and Pensions and a cross-appeal by the claimants, which is listed to be heard in July 2007. The Ombudsman has notified the parties that she will be an active participant in the appeal.

Prudential regulation of the Equitable Life Assurance Society

Our investigation into the prudential regulation of Equitable Life during the period prior to 1 December 2001 is ongoing. We continue to keep MPs and complainants informed about progress and we sent out our most recent update on 22 May 2007. As yet we can give no commitment as to the timetable for publication.

[4] *The Ombudsman in Question: the Ombudsman's report on pensions and its constitutional implications* (Sixth Report of Session 2005-06, HC 1081, July 2006).

[5] Public Administration Select Committee press notice, *House of Commons to debate Occupational Pensions*, 4 December 2006.



"Like all public bodies, the Health Service needs to be open and accountable at all times."

The National Health Service

In 2006-07 we reported on 1,139 health investigations. The complaints we investigate are only a small proportion of the many thousands of complaints which the NHS deals with each year, but they are among the most serious. The vast majority of complaints are dealt with at local level by NHS bodies.

Prior to July 2004, if complainants remained dissatisfied after their complaint had been dealt with by an NHS body, they could ask a convener (generally a non-executive member of the organisation complained about) for an independent review by a panel of lay people, which had access to clinical advice. This was known as the second or independent review stage of the NHS complaints procedure. This Office considered cases where the complainant was not satisfied with, or was not offered, an independent review.

The NHS complaints procedure was revised in July 2004, at which point the Healthcare Commission (the Commission) became responsible for carrying out the independent review stage. Most cases we reported on in 2006-07 had been dealt with under the new procedure. However, we still received a substantial number of complaints which were dealt with by the NHS under the old procedure.

Complaints about the NHS are received in this Office in a variety of ways. A significant proportion of our complaints have been reviewed by the Commission with the complainant having remained dissatisfied and having complained to this Office. We start by investigating the handling of the complaint by the Commission, to

determine whether there were shortcomings in the Commission's process, decision or service.

Where we uphold a complaint because we have found the Commission's process to be flawed or its decision unreasonable, we will not normally investigate the original complaint ourselves, but will refer the complaint back to the Commission for them to remedy the situation. We would consider investigating the original complaint ourselves in cases where we may not be confident of the Commission's ability to conduct an adequate investigation, or to do so in a reasonable timescale, or where we consider that the circumstances or experience of the complainant are such that it would not be reasonable for them to be referred back to the Commission.

In exceptional cases complaints are referred to us direct by the Commission, under a protocol for direct referral agreed between this Office and the Commission. Such referrals are agreed on a case-by-case basis, and could, for example, involve a complaint where the individual concerned has a terminal or significantly degenerative illness.

In other instances, we exercise our discretion to investigate, even though the complainant has not invoked and exhausted the NHS complaints procedure, as is normally required. An example of this may be where trust in the NHS complaints procedure has completely broken down, to the extent that the complaint is unlikely to be resolved locally or by the Commission.

Facts and figures

Figure 5 summarises the method of closure for health cases, showing separately cases in which we received complaints about decisions on whether patients should receive full NHS funding for long-term care (continuing care).

We fully or partly upheld 52% of complaints, excluding those about continuing care (85% fully or partly upheld). Many of the complaints we receive cover several issues and sometimes more than one health body. They are often complex, involving issues about clinical care and treatment.

Figure 5
Health cases accepted and concluded in 2006-07

	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	In hand at 1.4.07
Health – continuing care	199	239	7	9	352	70
Health – other	521	623	37	22	787	298
Health – total	**720**	**862**	**44**	**31**	**1,139**	**368**

† See 'Our workload and performance' for an explanation of the restatement of 1 April 2006 figures

Figure 6a shows the uphold rates for different types of health body.

Figure 6b shows the proportion of complaints reported on by type of health body.

This year complaints arising under the revised NHS complaints procedure comprised an increasing proportion of our caseload. The number of complaints we reported on that came through the former NHS complaints procedure has decreased accordingly. Figure 7 shows the distribution of cases by Strategic Health Authority area.

Figure 6a
Health complaints by type of body 2006-07

	Reported on	% upheld	In hand at 1.4.07
Ambulance Trust	6	83%	1
Foundation Trust	37	54%	10
General Dentist Practitioner	16	47%	3
GP	89	21%	12
Healthcare Commission	484	52%	252
Mental Health Act Commission	2	0%	0
Mental Health, Social Care and Learning Disability Trusts	60	75%	9
NHS Hospital, Specialist and Teaching Trusts (Acute)	170	66%	26
Primary Care Trust	289	72%	64
Strategic Health Authority	199	88%	31
Other Health Service Provider**	4	0%	3
Total	**1,356**	**62%**	**411**

**Other Health Service Provider includes NHS Direct, NHS Litigation Authority, Dental Practice Board and an optican

Figure 6b
Health category type by investigations reported on

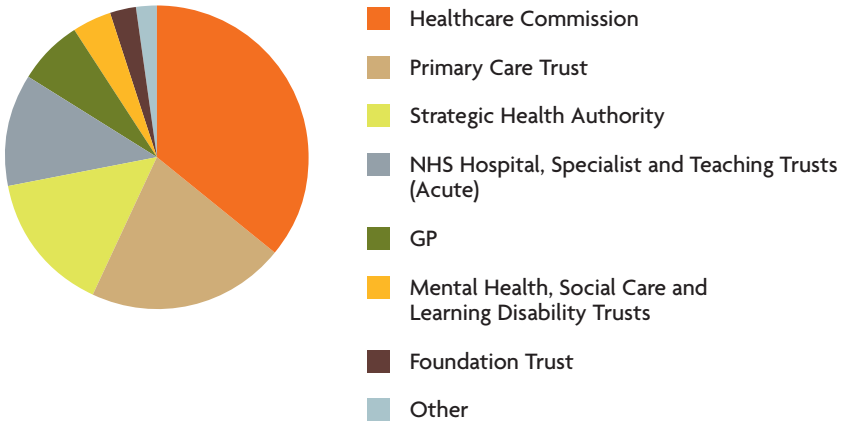


Figure 7
Distribution of continuing care health cases by Strategic Health Authority area 2006-07

New SHA	Previous SHAs	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	% upheld	In hand at 1.4.07
East Midlands Strategic Health Authority	Trent Leicester, Northamptonshire and Rutland	28	26	0	0	47	94%	7
East of England Strategic Health Authority	Norfolk, Suffolk and Cambridgeshire Essex Bedfordshire and Hertfordshire	12	26	0	0	25	84%	13
London Strategic Health Authority	North Central London North East London North West London South East London South West London	20	18	2	1	33	73%	2
North East Strategic Health Authority	Northumberland, Tyne and Wear County Durham and Tees Valley	7	4	0	0	11	73%	0
North West Strategic Health Authority	Cumbria and Lancashire Cheshire and Merseyside Greater Manchester	38	50	2	3	63	81%	20
South Central Strategic Health Authority	Thames Valley Hampshire and Isle of Wight	20	22	0	0	34	91%	8
South East Coast Strategic Health Authority	Surrey and Sussex Kent and Medway	10	30	0	1	32	78%	7
South West Strategic Health Authority	Avon, Gloucestershire and Wiltshire Dorset and Somerset South West Peninsula	39	41	2	3	69	86%	6
West Midlands Strategic Health Authority	Birmingham and Black Country Shropshire and Staffordshire West Midlands South	18	8	0	1	21	90%	4
Yorkshire and The Humber Strategic Health Authority	North and East Yorkshire and Northern Lincolnshire West Yorkshire South Yorkshire	7	14	1	0	17	94%	3
	Total	**197**	**239**	**7**	**9**	**352**	**85%**	**70**

† See 'Our workload and performance' for an explanation of the restatement of 1 April 2006 figures

Figure 7
Distribution of non-continuing care health cases by Strategic Health Authority area 2006-07

New SHA	Previous SHAs	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	% upheld	In hand at 1.4.07
East Midlands Strategic Health Authority	Trent Leicester, Northamptonshire and Rutland	25	4	4	1	21	62%	3
East of England Strategic Health Authority	Norfolk, Suffolk and Cambridgeshire Essex Bedfordshire and Hertfordshire	26	8	0	3	26	69%	5
London Strategic Health Authority	North Central London North East London North West London South East London South West London	85	10	7	6	72	63%	10
North East Strategic Health Authority	Northumberland, Tyne and Wear County Durham and Tees Valley	13	1	1	0	10	80%	3
North West Strategic Health Authority	Cumbria and Lancashire Cheshire and Merseyside Greater Manchester	49	9	2	2	46	74%	8
South Central Strategic Health Authority	Thames Valley Hampshire and Isle of Wight	23	4	0	0	19	58%	8
South East Coast Strategic Health Authority	Surrey and Sussex Kent and Medway	12	4	1	0	26	69%	4
South West Strategic Health Authority	Avon, Gloucestershire and Wiltshire Dorset and Somerset South West Peninsula	26	5	0	1	26	54%	4
West Midlands Strategic Health Authority	Birmingham and Black Country Shropshire and Staffordshire West Midlands South	31	1	0	2	29	55%	1
Yorkshire and The Humber Strategic Health Authority	North and East Yorkshire and Northern Lincolnshire West Yorkshire South Yorkshire	24	2	0	0	25	76%	1
	Healthcare Commission	189	574	21	7	484	53%	251
	Other national organisations*	3	1	1	0	3	0%	0
	Total	**506**	**623**	**37**	**22**	**787**	**58%**	**298**

* This contains the Mental Health Act Commission and the Dental Practice Board
† See 'Our workload and performance' for an explanation of the restatement of 1 April 2006 figures

Figure 7
Distribution of health cases by Strategic Health Authority area 2006-07

New SHA	Previous SHAs	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	% upheld	In hand at 1.4.07
East Midlands Strategic Health Authority	Trent Leicester, Northamptonshire and Rutland	49	30	0	1	68	84%	10
East of England Strategic Health Authority	Norfolk, Suffolk and Cambridgeshire Essex Bedfordshire and Hertfordshire	42	34	4	3	51	76%	18
London Strategic Health Authority	North Central London North East London North West London South East London South West London	105	28	9	7	105	66%	12
North East Strategic Health Authority	Northumberland, Tyne and Wear County Durham and Tees Valley	20	5	1	0	21	76%	3
North West Strategic Health Authority	Cumbria and Lancashire Cheshire and Merseyside Greater Manchester	87	59	4	5	109	78%	28
South Central Strategic Health Authority	Thames Valley Hampshire and Isle of Wight	43	26	0	0	53	79%	16
South East Coast Strategic Health Authority	Surrey and Sussex Kent and Medway	37	34	1	1	58	74%	11
South West Strategic Health Authority	Avon, Gloucestershire and Wiltshire Dorset and Somerset South West Peninsula	65	46	2	4	95	77%	10
West Midlands Strategic Health Authority	Birmingham and Black Country Shropshire and Staffordshire West Midlands South	48	9	0	2	50	70%	5
Yorkshire and The Humber Strategic Health Authority	North and East Yorkshire and Northern Lincolnshire West Yorkshire South Yorkshire	32	16	1	1	42	83%	4
	Healthcare Commission	189	574	21	7	484	53%	251
	Other national organisations*	3	1	1	0	3	0%	0
	Total	**714**	**862**	**44**	**31**	**1,139**	**66%**	**368**

* This contains the Mental Health Act Commission and the Dental Practice Board
† See 'Our workload and performance' for an explanation of the restatement of 1 April 2006 figures

The section entitled 'Our Workload and Performance' provides further details of our work on health enquiries and investigations.

Failing to observe the Principles of Good Administration

Many of the cases on which we reported during the year demonstrate the relevance of these *Principles of Good Administration* to the health service:

- **Getting it right**
- **Being customer focused**
- **Being open and accountable**
- **Acting fairly and proportionately**
- **Putting things right**
- **Seeking continuous improvement**

Getting it right

The Principle of 'Getting it Right' means, among other things, taking *'proper account of established good practice'*. Despite the existence of national standards and professional guidance for care and treatment, our investigations reveal that patients sometimes receive a standard of care below that which they should expect. The case of Mrs Z opposite, who was in great pain but received very poor care, illustrates many common features of complaints. It also revealed significant systemic problems at the Trust concerned. This case came to us through the pre-2004 NHS complaints procedure.

Case study
Ref. HS-2503

Care and treatment of an older person

Complaint against an NHS Trust

Mrs Z, suffering from abdominal pain, was admitted to the hospital managed by the Trust on 13 September 2002. She was diagnosed with periumbilical hernia and protrusion of a loop of the intestine through a weakened section of the abdominal wall, with signs of obstruction of the small bowel. A consultant surgeon who reviewed her on 16 September concluded that she had an intestinal obstruction and an emergency laparotomy to open the abdomen was carried out the same day. This revealed that the hernia was not the cause of the obstruction but that Mrs Z had a gallstone ileus (obstruction) due to two large gallstones. The stones were removed and the hernia was repaired, though it was noted that some stones remained in the gall bladder. Mrs Z was discharged on 27 September. She was readmitted on four more occasions within a period of five weeks with symptoms of pain and constipation. During her fifth admission Mrs Z was diagnosed with a recurrent gallstone ileus. An emergency laparotomy was performed. Mrs Z subsequently developed multiple organ failure and died on 29 October 2002.

Mrs Z's daughter, Mrs Y, complained that: there was a failure to consider a diagnosis of recurrent gallstone ileus; Mrs Z received inadequate care and treatment; and the convener failed to take independent clinical and nursing advice.

We found that when Mrs Z was readmitted to hospital there was a clear failure by the consultant surgeons to consider a diagnosis of recurrent gallstone ileus, until her fifth and final admission, despite it being known that large stones remained in Mrs Z's gall bladder after the first laparotomy. The Trust accepted this finding.

There was a lack of clear responsibility for Mrs Z's care following her first admission and she received care of an extremely poor standard as a result of a wide range of systemic failures. These included inappropriate discharge from hospital, non-reporting of X-ray films, poor record keeping, poor pain control, poor care planning, lack of nutritional monitoring and inadequate communication between clinicians.

In addition, the convener, when considering Mrs Y's complaint about her mother's care, failed to take independent clinical advice when it was appropriate and mandatory to do so.

We upheld all aspects of Mrs Y's complaint. We also made recommendations to assist the Trust in addressing the very serious issues raised by this investigation, the majority of which were systemic. The Trust agreed to implement these recommendations and indicated that it had already introduced new practices in response to the issues raised by this complaint. The Trust also apologised to Mrs Y.

Being customer focused

Our investigations often highlight a lack of focus on the patient - the person for whom the service is provided. Failure to observe the Principle of 'Being customer focused' is especially obvious in complaints involving vulnerable people: older people, those with a mental illness and children or adults with special needs. These people are more likely to have complex and enduring needs and to suffer complications or a rapid deterioration of their condition. They are usually the least able to express their needs or to complain when things go wrong.

This is illustrated by a number of cases highlighting deficiencies in the care and treatment of older people. Recurrent problems include: poor communication between professional groups in hospital and in the transfer of care to the community; lack of attentive care, which is sometimes tantamount to neglect; inadequate assistance with feeding; and poor risk assessment, revealed by a number of complaints about falls and handling.

In the case mentioned previously (page 33) Mrs Z was an older and vulnerable person, unlikely to complain. Trust staff have acknowledged that she was more likely to suffer in silence than to draw attention to herself. Her pain was not adequately controlled and it is apparent that there was a failure to take Mrs Z's family's concerns seriously and to respond to them appropriately.

We have carried out a number of substantive investigations of complaints involving people with a mental illness. We decided to investigate the substance of their complaint because these people had experienced considerable distress in making a complaint in the first place, and it would have been inappropriate to refer their complaint back to the Commission for reinvestigation. Common themes include: poor care planning and failure to follow the national guidance on the Care Programme Approach; inadequate explanations of care and treatment; and a tendency to disregard people's views and concerns.

People with special needs, whether they have a learning or physical disability, should routinely have those needs taken into account in their care planning and treatment. Regrettably, a number of cases we investigated this year show that NHS bodies sometimes fail to make adequate arrangements. This is illustrated by the following case which was received through the pre-2004 NHS complaints procedure.

Case study
Ref. HS-4160

Care and treatment of a person with learning disabilities

Complaint against an NHS Trust

Ms A, who has learning disabilities, was a regular attendee at the Trust for haemodialysis. On 24 September 2003, she was put on a dialysis machine. Shortly afterwards, her arm began to swell up and was painful. When Ms A told the Senior Staff Nurse, Ms A said that the Senior Staff Nurse told her there was nothing wrong with her arm and that it was like that when she had arrived. Ms A said that the Senior Staff Nurse repeatedly told her that the needle had not bumped (when the dialysis needle goes through the vein and into the surrounding tissue). However, another nurse noticed that the needle had bumped, and removed it. This incident frightened and upset Ms A.

At Ms A's next dialysis appointment, she told the Senior Staff Nurse that she did not want her to put her on the dialysis machine any more. This meant that at Ms A's following dialysis appointments she had to wait for other nurses to be available to care for her, so she was nearly always the last on the dialysis machine. While waiting to be put on the dialysis machine she was not offered anything to eat or drink.

Ms A and Mr B, her main carer, had previously had a very good relationship with the nurses and other patients. Following the bumped needle incident they felt this had deteriorated. Ms A thought that the Senior Staff Nurse was aggressive towards her and thought that she had heard the Senior Staff Nurse make what she felt were unpleasant and derogatory comments.

Mr B complained on 7 February 2004 on Ms A's behalf that she was provided with an inadequate standard of care and treatment on 24 September 2003, which had affected her care since that date and that the Trust's handling of the complaint was unsatisfactory.

We upheld Mr B's complaint about Ms A's care in that the Trust failed adequately to plan for her care, did not address or show an understanding of her learning disabilities and delayed taking action to address the incident of the bumped needle. However, we were unable to determine what happened at the appointment when the bumped needle incident occurred or whether the Senior Staff Nurse made any derogatory comments. The Senior Staff Nurse and Ms A's accounts of events could not be reconciled.

The evidence shows that the Trust attempted to resolve the complaint rapidly. However, their investigation was muddled, they did not interview all the staff concerned and did not seek advice from an expert in learning disabilities from the outset of the complaint. We therefore upheld the complaint about the Trust's handling of Mr B's complaint.

The Trust agreed to implement our recommendations to:

- review arrangements for Ms A's dialysis appointments to see whether a solution could be reached which would make Ms A feel safe. This review should involve a discussion with Ms A and a learning disabilities adviser;
- make sure that staff specifically address the needs of patients with learning disabilities when planning their care;
- provide training for staff on assessing the needs of patients with learning disabilities;
- review its complaints policy so that: the investigation team seeks specialist advice where necessary; information on local advocacy services is included in replies to complaints; and complainants receive a formal written response to their complaint; and
- review the way it deals with complaints to ensure it complies with the Disability Equality Duty under the Disability Discrimination Act.

Seeking continuous improvement

One of the *Principles of Good Administration* is 'Seeking continuous improvement'. In line with this, many of the recommendations we make to NHS bodies involve changes to policy or practice where a complaint has revealed a more widespread problem. Complainants often say they complained in order to prevent others experiencing the same problems in the future. NHS bodies also tell us that they find our recommendations helpful in improving their services.

'I would like to thank you and the Professional Adviser for your independent view of our processes... Your constructive suggestions have helped us to directly improve our systems.'
(NHS and Social Care Partnership Trust, HS-390)

Being open and accountable

Like all public bodies, the Health Service needs to be open and accountable at all times. But inadequate communication with patients, their relatives and carers is often a factor in the complaints we investigate. The case of Ms A, sent to us under the pre-2004 NHS complaints procedure, illustrates the impact on a patient of poor communication by a consultant.

Case study
Ref. HS-8953

Communication between consultant and patient about diagnosis

Complaint against an NHS Trust

Ms A had seen Dr B, a consultant neurologist, between 1978 and 1996. She was diagnosed with Multiple Sclerosis (MS) in 1979 and subsequently treated for that condition. Despite the evidence from an MRI scan in 1994, Dr B had never told Ms A that the diagnosis of MS might be questionable or indicated that she might not have it, nor did he suggest that she seek a second opinion or undergo further tests to be sure that she did have it.

Ms A was very distressed to learn in 2002 from Dr D, another consultant neurologist, that there were grounds to doubt the diagnosis of MS. She could not believe that these doubts had not been shared with her before. She received only a perfunctory apology from the Trust. Furthermore, she did not receive a full explanation of why Dr B discharged her from the Trust's Neurology Clinic in October 2006 without telling her the MS diagnosis was questionable. Ms A complained that she had suffered unnecessary distress as a result. She also felt that the Trust, in treating her as a person with a particular condition, had lost sight of her as a whole person with emotional and psychological as well as physical needs.

We found that Ms A was not denied any treatment option as a result of not being told about the uncertainty of the MS diagnosis and her physical condition did not suffer as a result. However, we found that Ms A was justified in believing that it was a serious failing not to have alerted her to the possibility that she might not have MS. We also agreed that the possibility should have been shared with her before she was discharged. This would have allowed her to reflect on the implications for her life and health as a whole.

We therefore upheld the complaint, recommending that the Trust make a consolatory payment of £1,000 to demonstrate the sincerity of its apology, which it agreed to do.

Putting things right: the complaints system

An effective complaints system is crucial if public bodies are to put things right. So it is disappointing that national developments on complaints handling did not progress as quickly during the year as we had hoped. This is in spite of the progress we noted in last year's annual report in response to the recommendations of our report *Making things better? A report on the reform of the NHS complaints procedure* (HC 413, March 2005). However, it is promising that momentum appears to be picking up again. On 18 June 2007, the Department of Health issued a consultation paper on proposed integrated arrangements for health and social care complaints handling, following its commitment in the White Paper, *Our health, our care, our say* in January 2006. There is still much work to be done before the proposals become a reality, but we hope this will make it simpler for people to make a complaint that crosses service boundaries.

Making things better? advocated a shared commitment to improvement in complaints handling at every level of the NHS. We urged leadership from the Department of Health in setting standards that all NHS complaints handlers should achieve. We highlighted the important role of the Healthcare Commission (the Commission) as regulator in ensuring that good complaints handling features strongly in the inspection and performance regime. At local level, we said that improvements in complaints handling should be underpinned by a corporate commitment to taking complaints seriously and learning the lessons arising from them. The Ombudsman should be the last resort for the most complex, difficult and intractable complaints. If the NHS is treating complaints seriously and handling them properly, neither the Commission nor the Ombudsman should need to be a volume complaints handler.

Nonetheless, evidence indicates that there is still a long way to go before complaints handling is taken as seriously as it should be across the NHS. We recognise that NHS bodies have many pressing priorities, but they vary greatly in their level of commitment to good complaints handling. We would expect to see NHS bodies monitoring complaints as an integral part of clinical governance and risk management. However, not all Boards do this regularly or thoroughly, even though all NHS Trusts are required to have a Board member with responsibility for complaints.

Common failings include excessive delays in responding to complaints or in notifying complainants of decisions, failure to take clinical advice when it is necessary and appropriate and failure to provide information to complainants about how to request an independent review. It is also disturbing that there is sometimes a reluctance to take people's concerns seriously, as the following case demonstrates.

Case study
Ref. 11132

Refusal to investigate a complaint about care and treatment

Complaint against an NHS Trust, directly referred to the Ombudsman by the Commission

After a psychotic episode, Mr E was detained under the Mental Health Act from July to October 2003, when he was discharged. He was then seen as an out-patient up to January 2005. Mr E first formally raised his concerns about inadequate care and treatment during his admission with the Independent Complaints Advocacy Service (ICAS) in August 2004. He said he had been so traumatised by his experience that he had not been able to speak to anyone about it for a year. ICAS assured him that his complaint would not be judged out of time under the NHS (Complaints) Regulations 2004 since he was receiving ongoing care and treatment as an out-patient. Mr E complained to the Trust in writing on 21 January 2005. The Trust complaints manager informed him on 8 February that his complaint would not be investigated because of the time that had elapsed.

ICAS asked the Trust to reverse its decision, since Mr E became aware of his need to complain about his 2003 admission only in August 2004. His formal complaint followed within the six-month timescale, in January 2005. However, the Trust continued to refuse to investigate. ICAS therefore requested an Independent Review from the Commission on the basis that the Trust had failed to use its discretion flexibly and sensitively to investigate Mr E's 'out of time' complaint. The Commission asked the Trust in November 2005 to review its decision not to investigate the complaint, since they considered Mr E met the criteria for making a complaint within the time limit. However, the Trust continued to assert that it would not pursue the matter or carry out a formal investigation.

In January 2006, the Commission directly referred Mr E's complaint to the Ombudsman.

We found that the Trust failed to adhere to the Regulations since it had not: provided a response by the Chief Executive to a formal complaint and an explanation of the next stage of review; exercised its discretion to waive the time limits; and complied with the Commission's decision that the Trust should investigate the complaint. We therefore upheld Mr E's complaint on the basis of flawed process and we were highly critical of the Trust.

However, we found that Mr E's clinical care and treatment were of a reasonable standard and we did not uphold this element of his complaint.

Complaints reviewed by the Healthcare Commission

The Commission reviews complaints which have not been resolved locally. The National Health Service (Complaints) Regulations 2004 govern the way in which the Commission manage these complaints. If a complainant is dissatisfied with the Commission's decision or the way it handled the complaint, he or she can complain to the Ombudsman. When considering such complaints we first assess the Commission's handling of the case.

During the year we accepted 575 such complaints for investigation. We reported on 484 cases and of those, we fully upheld 34% and partly upheld 18%. We also received increasing numbers of enquiries relating to the Commission. The most common reason for not accepting a complaint for investigation is that people contacted us before approaching the Commission or before the Commission had completed its review. We have liaised closely with the

Case study
Ref. HS-8891

The Healthcare Commission's review of a complaint against a GP

Mrs N complained to the Commission about the care and treatment provided to her by Dr Z when Mrs N found a lump in her breast. The Commission's review found that Dr Z had failed to follow the referral guidelines for suspected breast cancer. They found that Dr Z had also failed to ensure that Mrs N fully understood that a non-urgent referral to the breast clinic was being made and how long it might take to get an appointment.

The Commission recommended that the Primary Care Trust should consider whether Dr Z should be referred to the National Clinical Assessment Service, the body responsible for assessing a doctor's performance if it gives cause for concern. Dr Z's colleague, Dr L, disagreed with the outcome of the Commission's review and complained to the Ombudsman on behalf of Dr Z about the conduct and decision of the review.

We upheld Dr L's complaint. We found that: the Commission did not obtain all of the relevant clinical records; they appeared to give more weight to Mrs N's evidence than that of Dr Z; the Commission's case manager misinterpreted the referral guidelines and gave the clinical adviser an inaccurate summary of the case; and the panel system used to obtain clinical advice in this case was inadequate. We found that Dr Z had acted in accordance with the guidelines and that the Commission's recommendation was inappropriate.

The Commission accepted our recommendations, including that they should:

- apologise to Dr L and Dr Z for the failings identified;
- review how they obtain and use clinical advice. The Commission told us that, since 2004, they have changed the way clinical advice is obtained and a suitably qualified clinical adviser is given the necessary documents and records before producing a report;
- seek advice from a suitably qualified clinical adviser with access to the relevant papers if they intend to question the competence of GPs;
- consider whether it would be good practice to share draft reports.

Commission this year to assist them in improving their standards of complaints handling.

The cases we saw during the year demonstrate that the Commission has developed and improved its complaints handling. We upheld some complaints about unreasonable delay, during which the Commission failed regularly to update the complainants on progress. These complaints dated from the early stages of the Commission's complaints handling role, when it received many more complaints than forecast. Since then, it has generally maintained regular contact with complainants, including during the period when it had to manage a backlog resulting from an unexpectedly high volume of cases. A number of cases show that the Commission reviewed complaints efficiently and proportionately. Complex reviews are carried out more systematically against relevant guidance and standards and there is a more structured approach to seeking clinical advice.

We also noted a number of areas that required improvement. These included: the explanation of the Commission's jurisdiction; its approach to redress; agreeing and clarifying the nature of the initial complaint; the thoroughness of investigations and evidence gathering; the seeking and use of clinical advice; and the provision of a clear explanation in reports. Two case studies (on pages 39 and 41) illustrate some of these issues. In the first, we investigated the Commission's handling of the complaint.

In the second case, we investigated the Commission's handling of the complaint and subsequently returned the complaint to the Commission for further work.

Case study
Ref. PA-12171

The Healthcare Commission's review of a complaint about the care and treatment of an elderly patient

Mr H, aged 83, was admitted to hospital on referral by his GP on 24 October 2003 with increasing shortness of breath. He was briefly cared for on C Ward (the admissions ward) and then moved to G Ward (a general medicine and respiratory ward). On 27 October he was considered well enough for discharge. However, on 29 October he became unwell with a high temperature and was started on intravenous antibiotics. By 30 October, his temperature had settled and medical staff considered his condition had improved. He was transferred to J Ward (a general surgical ward that accepts outlying patients from specialist wards) that evening and started on oral antibiotics on 4 November, with a planned discharge of 7 November. However, by 7 November he had developed a raised temperature again and was transferred back to G Ward. He continued to be unwell and a clear deterioration in his condition was noted on 11 November. Mr H died the following day.

Mrs H complained that her husband was placed on an inappropriate ward (J Ward) where staffing levels were inadequate to meet the dependency levels of the patients. Mr H's condition was inadequately monitored there and medical staff failed to notice that he was deteriorating. Arrangements were put in place to discharge Mr H despite his deterioration. Although Mrs H asked to see a doctor to discuss her concerns, this was not arranged.

The Trust considered Mrs H's complaint and assured her that: Mr H's transfer to J Ward was appropriate since he was assessed as stable and remained under the same consultant; that the plans for discharge complied with the Trust's discharge policy; and that the medical team would not have discharged Mr H until they felt he was well enough. Dissatisfied, Mrs H complained to the Commission, which took clinical advice and confirmed the Trust's own findings.

Mrs H considered that the Commission did not address the issues satisfactorily and her complaint was referred to the Ombudsman. We upheld the complaint against the Commission since we found a number of flaws in their investigation. We found evidence to suggest that Mr H was already unwell before his transfer to J Ward. In addition, the Commission did not:

- address the issue of the adequacy of staffing levels on J Ward;

- seek clinical advice on the monitoring of Mr H's condition while he was on J Ward or consider the standard of record keeping and documentation;
- consider whether there was evidence of formal documentation on discharge arrangements and did not appear to have reviewed the hospital's discharge policy;
- address Mrs H's complaint about the difficulty she experienced in arranging to see a doctor.

We returned the complaint to the Commission, recommending that they reinvestigate the complaint and, in particular, obtain appropriate clinical advice to address these issues.

Putting things right: remedy

When mistakes occur, ensuring that injustice is remedied is an important part of our work. In addition to establishing the facts of a case and determining whether a complaint is justified, we make recommendations for remedy where a complaint is upheld. The draft *Principles for Remedy*, on which we consulted this year, provide a framework for the approach to take when remedying injustice or hardship.

Recognition of the appropriateness in some circumstances of financial redress for mistakes is gaining ground in the NHS. The NHS Redress Act 2006, was a step towards this. It reforms the way lower value negligence cases will be handled so that a suitable remedy (including financial redress where appropriate) can be provided without the complainant having to go to court. However, the detailed regulations on how and when this will be achieved are still awaited.

The following two cases illustrate our approach to remedy. Both involve financial redress as well as recommendations for changing policies or procedures. The first case, which came to us through the pre-2004 NHS complaint procedure, demonstrates that redress can come through action from a combination of bodies.

The second case was one in which the Ombudsman exercised her discretion to investigate, although it had not gone through all the stages of the NHS process.

Case study
Ref. HS-2341

Remedy for a patient following a cataract operation

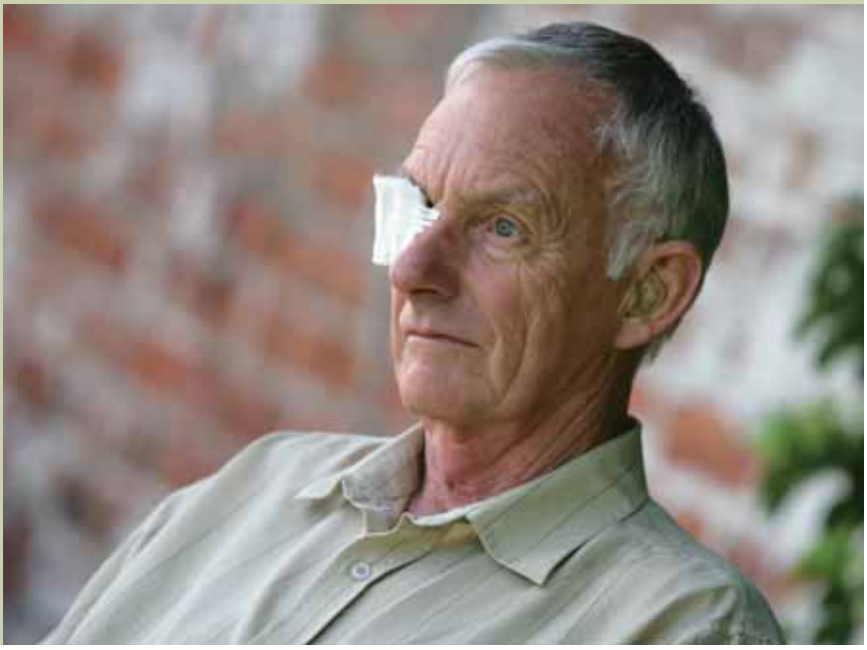
Complaint against an NHS Trust

Mr A was diagnosed with glaucoma, which made him totally blind in his left eye and partially sighted in his right eye. In 1990, Mr A was informed that his left eye was beyond repair, but that the right eye, though badly affected, would give him useful vision for the rest of his life. In 2003, Mr A underwent a cataract operation on his right eye, which was described as uneventful. After the operation, however, Mr A experienced deterioration in the sight of his right eye. He also suffered from post-operative inflammation, for which he was treated at A&E.

Mr A complained that: he was not informed before the operation of the risk of losing his existing level of sight; he should not have undergone the operation on his right eye because of his advanced glaucoma; he was provided with a poor standard of post-operative care; and he should not have been transferred back to the care of his local hospital so soon after the operation.

We found that the risks of the operation were properly explained to Mr A, including the possibility of surgery damaging the vision in some circumstances and that having advanced glaucoma might affect the outcome. We also found it reasonable that Mr A was offered the cataract surgery as it did offer a realistic chance of improving his central vision. However, the most likely cause of the deterioration in Mr A's eyesight was a significant rise in the intraocular pressure (pressure within the eye) of his right eye following the operation. The Trust should have been proactive in anticipating this in a patient with advanced glaucoma who already had tunnel vision, but the surgical team followed the Trust cataract policy of not taking any additional action because the post-operative reading was not above a certain level. We therefore upheld the aspect of Mr A's complaint about poor post-operative care. However, it was appropriate for Mr A's care to be transferred back to his local hospital, so we did not uphold this part of the complaint.

The Trust agreed to our recommendation that it should review its cataract policy to ensure that it distinguishes between categories of patient so that appropriate care and treatment are provided. Mr A demonstrated to us that the deterioration in his eyesight, owing to the poor post operative care, had clearly had an adverse impact on his quality of life. We therefore also recommended that he should be offered financial redress to compensate him and that the Trust should refer the case to the NHS Litigation Authority for consideration. Mr A has now been awarded £5,000 in compensation.



Case study
Ref. HS-6273 and HS-6311

Provision of occupational therapy and physiotherapy to a child with special care needs

In two related complaints, Mr A complained about the provision of occupational therapy and physiotherapy by the Primary Care Trust to his son, G, who has special care needs.

Mr A's first complaint raised serious concerns about the absence of occupational therapy for G while attending school. G's Statement of Special Educational Needs recommended one hour per week of occupational therapy, but the occupational therapy service had not approached the Local Education Authority about providing it. Mr A considered that G's health and future development were affected. Mr A also complained about other, significant shortcomings in the occupational therapy service. He had attempted to have things put right, but there was no visible improvement to the service.

Mr A raised his concerns with the Ombudsman while his case was waiting for independent review by the Commission. Given the immediacy and seriousness of the concerns about G's welfare, the Ombudsman exercised her discretion to investigate, with the agreement of all parties. We found that there were serious failures of organisation and management in the occupational therapy service. This was compounded by poor communication and decision-making at many levels of the Trust. The result was that G was not receiving the service he should have received. We therefore recommended that the Trust urgently address the provision of occupational therapy to out-of-borough children and carry out an urgent review to identify the scope and core functions of the service, how it should be delivered and appropriate staffing levels. The Trust agreed to all the recommendations and apologised to Mr A.

Mr A's second complaint concerned the provision of physiotherapy to G while attending a nursery and later at an infants school. Following Mr A's dissatisfaction with the Trust's original response, the Trust's Independent Review Panel made recommendations to the Trust to put things right. But, despite attempts to get information from the Trust about their

implementation, Mr A did not receive a response. It took the Trust a year to provide a formal response to Mr A and that was as a result of the Ombudsman's intervention. Even then, the Trust did not explain the reasons for the delay and lack of communication with Mr A.

Our investigation found that the physiotherapy service provided to G fell below the standard he should have received. We concluded that the Trust's delay in responding to the Independent Review Panel's recommendations, the absence of an explanation for the delay and the failure to apologise were maladministrative. We also found that the Trust's response to the recommendations did not adequately address problems with caseloads and resources, record keeping and the balance between paediatric physiotherapy and occupational therapy services. The Trust had been aware that there were not enough staff to cope with the high demand for paediatric physiotherapy services, but had not been sufficiently proactive in taking action.

We therefore recommended that the Trust should produce guidelines on procedures for reviewing children and on the structure of clinical notes and audit, following advice provided by the Association of Paediatric Chartered Physiotherapists and the Chartered Society of Physiotherapy. They should also review caseloads and the system for prioritising children. We recommended that the Trust consider making a consolatory payment to Mr A in recognition of the inconvenience, frustration and distress he and his family experienced. The Trust agreed to the recommendations and made a consolatory payment of £750 to Mr A.

G is now educated at home and Mr A told us that he had received a payment from the council for services that G had not received while he was at school. Mr A has also agreed to take part in the Trust's Service User Forum. Mr A said,

"I was delighted with the positive outcome of my complaint ...he is an altogether different child and this has gone a long way to improving his self-confidence and social skills. It is reassuring to know that the Ombudsman is there for children and families ... with genuine concerns that can be addressed and resolved".

Retrospective continuing care funding and redress (HC 386, March 2007).

Continuing care: remedying long standing problems

The NHS provides funding for long-term care for some people who have continuing care needs because of accident, illness or disability. It covers services from the NHS, local authorities and private providers. Arrangements for deciding who should receive NHS fully funded care have long been a matter for concern. The Ombudsman's special report[6] in February 2003 showed that some people were paying for their care when the NHS should have paid for it, causing distress and financial hardship. One of her recommendations was that Strategic Health Authorities and Primary Care Trusts should take steps to remedy retrospectively any injustice to those people and to any others in their area who had also

[6] NHS funding for long-term care of elderly and disabled people (HC 399, February 2003).

wrongly been made to pay for their care. Subsequently, the process of carrying out retrospective reviews of local funding decisions was fraught with difficulties. We received many complaints about delay, poor review processes and the application of overly restrictive eligibility criteria.

We have worked closely with both the Department of Health (DH) and Strategic Health Authorities to assist them in resolving the large numbers of complaints about the retrospective reviews. NHS bodies and the DH have made considerable efforts to put right the shortcomings we identified both in our 2003 special report, the follow-up report we produced in December 2004[7] and in our later investigation work. The number of outstanding complaints about reviews is now reducing and we are more confident that claimants will receive a robust, fair and transparent review of their eligibility. We also welcome the National Framework for NHS Continuing Care and NHS Funded Nursing Care in England, which the DH published on 26 June 2007 and which we first recommended in our 2004 report. The National Framework establishes national criteria for eligibility for continuing care funding and a framework for assessing who should receive it. It will come into operation on 1 October 2007, and will not be retrospective.

Continuing care complaints have been a decreasing part of our workload this year. We reported on 352 cases, compared with 1,097 the previous year, and had 70 cases in hand on 1 April 2007. We fully or partly upheld 85% of complaints investigated, a much higher proportion than for other types of health complaint.

Further details can be found in Figure 5 on page 28, Figure 7 on pages 30-32 and the section entitled 'Our Workload and Performance'.

As NHS bodies have carried out more retrospective reviews and reached decisions, we have received complaints about the amount of redress received. Since these revealed evidence of more widespread problems, we published a report on the results of our investigation into these complaints, *Retrospective continuing care funding and redress* (HC 386, March 2007).

Complainants alleged that the amount of recompense they had received from Primary Care Trusts (PCTs) did not fully compensate them for all the financial losses they had incurred while funding their care. PCTs said that they were following guidance from the DH in calculating the amounts payable. The Department's guidance advised paying the care costs the NHS should have paid, but took no account of other possible financial losses nor did it highlight PCTs' discretion to include an element of compensation for any distress and inconvenience suffered. Furthermore, the guidance advised calculating interest based on the retail price index (RPI) rather than the higher County Court judgment debt rate. The result was that there was inconsistency in the way PCTs calculated the redress due and the amount of compensation people received depended on where they lived.

[7] NHS funding for long term care: follow up report (HC 144, December 2004).

Where people had received social security benefits during the period for which they later received retrospective NHS funding, we concluded that they would not usually have suffered any unremedied injustice. This was because the Department for Work and Pensions had agreed not to reclaim those benefits. The total sum those people received (reimbursed care fees plus interest at RPI and retained benefits) would in most cases have at least equalled the amount of compensation received had the benefits been reclaimed and interest been calculated using County Court judgment debt rate. However, we were clear that PCTs should compensate any complainants who could provide evidence of financial loss.

PCTs were acting on DH advice and we concluded that the Department was maladministrative in deciding on its formula for redress and in the way it communicated its approach to the NHS. We therefore recommended that the Department should develop properly considered national guidance on continuing care redress. This should:

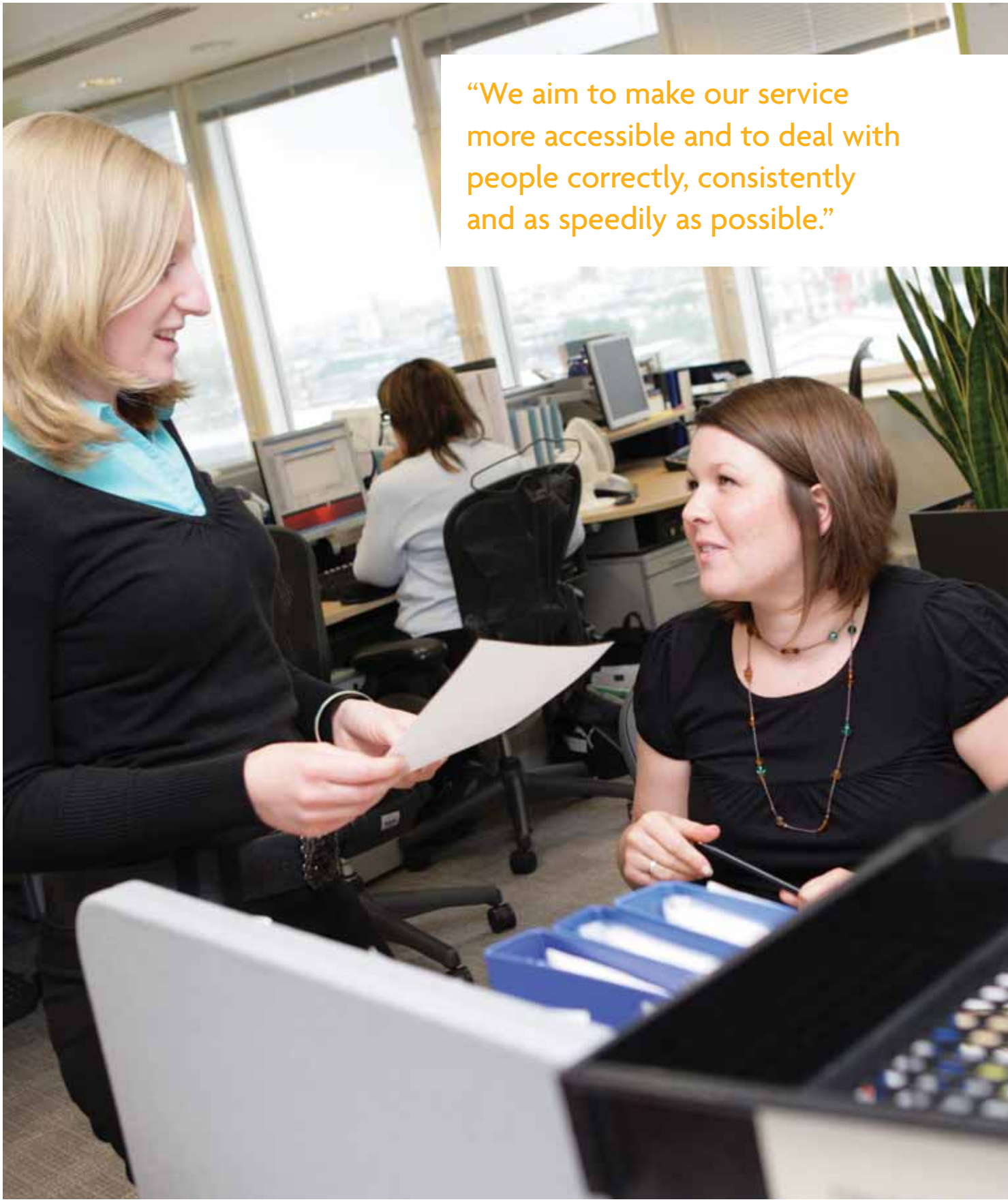
- remind PCTs that compensation payments should aim to return individuals to the financial position they would have been in if they had not been wrongly denied continuing care funding;
- clarify that PCTs are empowered to make payments in recognition of the inconvenience and distress caused;
- remind PCTs that local authorities can offer deferred payment agreements to people not eligible for NHS funding who might have to sell their homes to fund their care;
- provide advice on how to calculate interest payments.

The DH agreed to produce such guidance in response to our recommendations and issued *NHS Continuing Healthcare: Continuing Care Redress* on 14 March 2007, to coincide with the publication of our report.

With these developments on redress, the long-running saga of problems with continuing care retrospective funding should now be drawing to a close. It illustrates the importance of the Principle of *acting fairly and proportionately* in public services. However, we are concerned that there are still too many applicants for retrospective funding who have not had their applications properly determined. Some Strategic Health Authorities have found a way to address the remaining applications. We have asked the DH how they intend to bring this long standing problem to a resolution for all those involved. Subject to successful resolution of the remaining applications, we intend to publish a final special report in 2007-08. New (non-retrospective) complaints about continuing care funding will come through the NHS complaints procedure, as will complaints about the amount of compensation received in retrospective review cases. We are liaising closely with the Commission to ensure that a robust system is in place for determining those complaints.

Healthcare in prisons

A significant change to our jurisdiction this year involved the transfer to the NHS of the responsibility for commissioning healthcare for most prisoners in England and Wales from 1 April 2006. Complaints by prisoners about the healthcare they receive now go through the NHS complaints procedure, with the Ombudsman as the third and final tier. So far we have received fewer complaints than we might have expected, given the prison population. Until we have investigated and reported on more complaints, there is insufficient evidence to suggest reasons for this. However, we shall monitor themes arising from such complaints, including accessibility and the consistency of local complaints handling.


"We aim to make our service
more accessible and to deal with
people correctly, consistently
and as speedily as possible."

Developing our service

In suggesting that public bodies adopt the *Principles of Good Administration*, it is important that we apply them to every part of our own business. Providing a high quality complaints handling service is one of our strategic aims and everything we do should contribute to achieving it.

Customer focus

This year, we have consolidated and refined the new approach to handling complaints, which we introduced in 2005. We have acted on what complainants, bodies within jurisdiction and others have told us about our approach through formal and informal feedback.

Implementing improvements to the 'front end' of our complaints handling process is an organisational priority. During the second half of the year, we introduced a more systematic and consistent approach to assessing requests to investigate. Every complaint is considered by senior staff to decide whether the Ombudsman can and should investigate it or if there is a better route to achieving a suitable outcome. This enables us to decide the best way to handle individual investigations, to take a strategic overview of the complaints we receive and to identify recurring problems more quickly. It allows us to use our resources more effectively for the benefit of complainants and to plan for future demand for our service.

We are also restructuring our organisation to focus more clearly on the customer. A new Directorate of Customer Services and Assessment aims to make our service more accessible and to deal with people correctly, consistently and as speedily

Customers' comments on our service

"I could not have met a more professional response than [your investigator] gave me. She always replied as she promised and gave her full attention to the sorry details."
(Mrs D, complainant)

"Although I am disappointed that I will not receive any financial benefit, nevertheless I feel that my case was examined thoroughly and fairly. I can now accept the situation and move on."
(Mrs Y, complainant)

"Thank you for your comprehensive report following my complaint about the DWP. I felt it was very fair and focused on the points that were very important to me."
(Mrs A, complainant)

"I am very grateful for the very thorough investigation you have undertaken. I would also like to say how pleased I am to be given the chance to comment on the draft report."
(Ms X, complainant)

as possible from the point of their first contact with us. Even if we are unable to help directly, we try to assist people to find the right place to direct their enquiry.

We worked hard during the year to reduce the number of investigations in hand that had built up to a peak during 2005-06. As a result, we finished the year with 617 investigations in hand compared with 1,862 the previous year. In addition, we had only 73 investigations over a year old in hand and only six cases that had been accepted for investigation but had not yet been allocated after six weeks. This is an encouraging foundation on which to improve our performance and to achieve our customer service standards. More details are provided in the following section, 'Our Workload and Performance'.

Customers' views

Our customer satisfaction survey, run for us by Ipsos MORI between October 2005 and September 2006, measured how complainants felt we handled their complaints. Of the 1,258 complainants interviewed during that period, 63% were satisfied or very satisfied with the way in which their complaint was handled. Large numbers of complainants described us as accessible, responsive, sympathetic and fair. Staff were also described as friendly and helpful. Areas for improvement, which we recognise and accept, included reducing the length of time taken for investigations and managing complainants' expectations better in terms of what the Ombudsman can do and the possible outcomes.

This year, with the help of Opinion Leader Research, we also carried out a

Stakeholder views of the Ombudsman

"I find it very helpful sometimes to share things with [Ombudsman staff] and share their information and to bounce ideas off them and it has been a very fruitful partnership."
(Senior stakeholder)

"I think you do a very good job as far as we are concerned in actually picking out what the issue is because I think it is very complicated."
(Parliamentary complaint handler)

"I would be more than happy to call on the Ombudsman because they've always been incredibly approachable."
(Health complaint handler)

qualitative survey of our main stakeholders, including complainants, departmental and health service complaints handlers, the Commission, MPs, and advisory and other bodies. We are grateful to everyone who took part. Complaints handlers noted that our new approach to handling complaints is having a positive effect. They particularly welcomed the more flexible approach to investigations, sharing of best practice information and increased levels of dialogue.

The majority of stakeholders believed we have excellent case management practices, although managing complainants' expectations and enforcing recommendations were considered to be challenges for the Ombudsman. Finally, some complainants and other stakeholders thought we could investigate complaints more quickly, but no one wanted us to compromise the thoroughness of investigations in doing so.

We take all the views expressed very seriously and we will feed the messages emerging from both surveys into improvements in our service.

Complaints about us

We believe that we should live up to the standards we expect of others when we handle complaints. We also consider that complaints about our service give us important feedback to help us improve that service.

We received 1,219 complaints about us during the year, covering 1,310 heads of complaint. Of these, 1,097 related to the decision we had reached, 147 were about our service and a further 66 related to Freedom of Information Act and Data Protection Act requests.

We resolved 1,136 complaints about us during the year, of which we upheld 157.

Of these, in 34 cases (3% of the total), we identified an error in the decision, 69 (6%) needed a different or additional explanation and in 54 cases (5%) we found that our service had not been of the standard a complainant was entitled to expect from us.

Lessons arising from complaints about how we approach our work are fed back to staff and translated into changes in our procedures.

The Office receives relatively few legal challenges to its work, although numbers have increased over the past few years, which matches the experience of other public bodies. Very few of the challenges to the Ombudsman are successful, the vast majority failing even to receive permission to proceed to hearing.

During the year the Office was the subject of 10 judicial review applications, all of which were initially refused permission to proceed. The Office was awarded costs in all but two of those cases. Eight applications were subsequently renewed; three were again refused permission by the court, with costs being awarded to the Office, one was given permission to proceed (no hearing date yet fixed), and we are awaiting the results of the remaining four renewal applications.

Access to our services

Many respondents to our customer survey described us as accessible. However, we know from research carried out in previous years that awareness of the Ombudsman's services is low among certain people, including ethnic minority groups and younger people. Our stakeholder survey indicated that complainants' knowledge and understanding of the Ombudsman's role could be improved.

"I think you've got to make sure that the complainants know how to have access. Therefore you've got to think about how to get to them and that's not necessarily by the normal methods of communication, because a lot of these people are not able to access them."

(Senior stakeholder)

Some stakeholders also felt that requiring people to make a complaint to the Ombudsman about a government department or agency through their MP might prevent some people from complaining. Moreover, the multitude of complaints systems in force across the public services can make it difficult for potential complainants to know where to turn. For these reasons, we consider it a priority to improve awareness of our service and make putting a complaint to the Ombudsman as simple and straightforward as possible.

Since we cannot reach all the people who might want to use our service directly, we have developed close contacts with advocacy and advice bodies. These include Citizens' Advice and the Independent Complaints Advocacy Service of the NHS. We intend to strengthen our contacts with these bodies, and are developing an outreach strategy to help us achieve this.

During the year we continued to implement our equality and diversity strategy, which was based on research on external perceptions and staff views.

We have also continued to work with other Ombudsmen, particularly the English Local Government Ombudsmen, to make it easier for people whose complaints cross service boundaries to achieve a resolution.

Contributing to public service improvements

Our second strategic objective is to contribute to improvements in public service delivery. In addition to handling individual complaints, providing information and analysis from our casework is a powerful lever for change. Although we have done much in recent years to fulfil this role, our stakeholder survey indicated that it is less well known than our complaints handling role. We therefore intend to do more in the coming years to share good practice and the learning arising from complaints.

"I think what we don't often pick up on is how much services have improved as a result of the Ombudsman's decisions."
(Advisory body)

The *Principles of Good Administration*, have been well received. A wide range of bodies responded positively and constructively to the consultation. They included a co-ordinated response by the Cabinet Secretary on behalf of government departments. We were pleased that government departments found the Principles themselves relevant and helpful. Many other bodies said that the Principles resonate with their own values and

Responses to the Principles of Good Administration consultation

"We welcome the development of these Principles...They are written in a way which staff will find relevant and helpful to their work."
(Cabinet Secretary, co-ordinated response on behalf of government departments)

"I think that the (draft) Principles that you propose should support improvements in public administration and the way in which complaints are handled."
(Comptroller and Auditor General, National Audit Office)

"A clear guide to the standards against which NHS organisations should be held in their dealings with the public."
(South West Strategic Health Authority)

"We welcome the Principles and believe that the clarity they will provide both to complainants and bodies within jurisdiction will be invaluable."
(National Archives)

the standards they aspire to in their work. We followed this work up by consulting on draft *Principles for Remedy*. We hope that both sets of Principles will provide public bodies with a helpful framework within which to plan and deliver services and to put things right where they have gone wrong.

Learning and improvement is a two-way process. Sharing information and discussing issues of mutual interest with other UK Ombudsmen helps us to improve our service and working practices while contributing to developments in complaints handling. The British and Irish Ombudsman Association (BIOA) is a prominent forum for this and we have played an active role in it again this year. During the year, the Ombudsman responded to a number of important consultation exercises sometimes jointly with her public service Ombudsman colleagues in England, Scotland, Wales, Northern Ireland and Ireland. These include the British and Irish Ombudsman Association's draft *Guide to Principles of Good Complaint Handling*, the Department of Health consultation on the *Future regulation of health and adult social care in England* and the General Medical Council consultation on *Seeking Patients' Consent: the Ethical Considerations*.

During the year the Ombudsman and senior staff were invited to speak at conferences and meetings of professional groups. These included the Constitution Unit of University College London, the General Assembly of the International Ombudsman Institute (European Region), the Royal College of Psychiatrists, Action on Elder Abuse and the *Improving Care for Older People Conference*. Such speaking engagements provide the opportunity to raise awareness of the Ombudsman's role and to share learning from complaints with people who are in a strong position to bring about public service improvement. The Ombudsman has also given evidence to the Public Administration Select Committee on a number of occasions during the year, including to their inquiry *Public Services: Putting People First?*

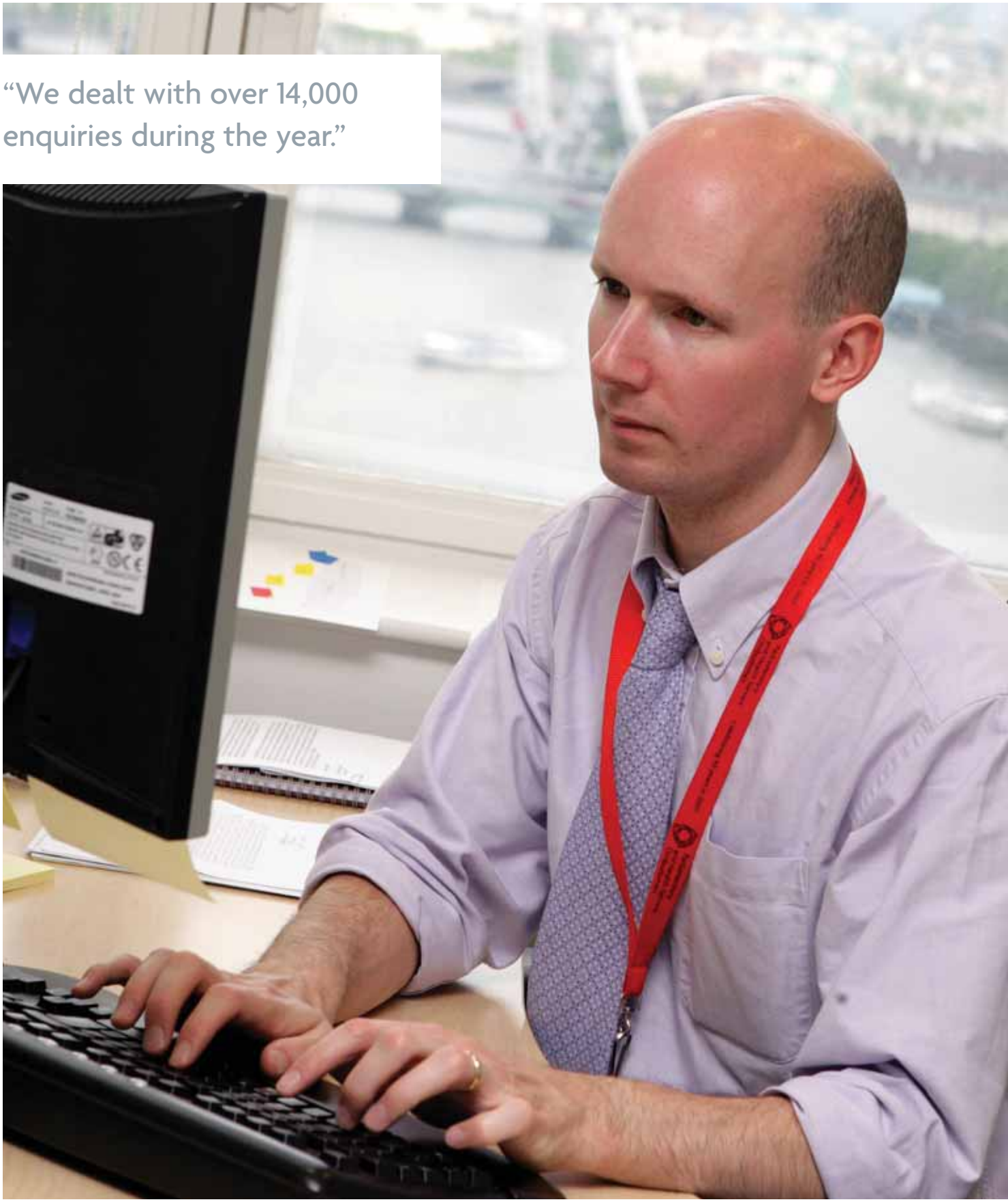
Developing our capacity

During the past two years we have made extensive changes to our complaints handling approach in order to improve our service to complainants and secure better outcomes. The high level of skill and commitment of our staff have made the successful implementation of these changes possible. To maintain this level of performance and to increase staff satisfaction we have made a significant investment in training and development.

With the assistance of consultants, Penna, we are working on a management development programme to enhance our management capacity and improve overall organisational performance. We are also developing a strategy for talent management, recognising the importance of 'growing our own' future caseworkers and managers.

Dealing effectively with equality and diversity issues is highly important to our business. We aim to be responsive to the differing needs and circumstances of customers and staff. To reflect the importance we attach to these issues, we developed and implemented an equality and diversity strategy and action plan. During 2006-07 we commenced an extensive programme of training for all staff to ensure that equality and diversity issues are fully integrated in our work. Among other things, this enables our staff to identify complainants with specific needs and to tailor their responses accordingly. We have also put in place arrangements to identify equality and diversity issues arising from our casework and to ensure that staff are aware of them. In addition, we have reviewed our employment policies to make sure that they are in line with our strategy.

"We dealt with over 14,000 enquiries during the year."



Our workload and performance: facts and figures

Introduction

Being accountable for our performance is important to us. In recent years, we have been working to improve our casework processes and to refine the way we record, monitor and report on the work we do. Our aim is to improve our service and to give greater consistency and clarity to our workload and performance information. We took some significant steps towards this aim during 2006-07.

Because different reporting methodologies were being used, the figures for 2006-07 are not directly comparable with the figures reported for 2005-06. However, following the development of our performance reporting and the improvement in data quality, we are now much closer to establishing, and being accountable for, a consistent baseline of workload and performance.

Enquiries

The number of contacts made with the Office has not changed significantly over the past year, but the overall number that we record as 'enquiries' is lower. That is because repeated contacts about the same complaint are no longer recorded as separate enquiries.

Investigations

The figures in this Report show that we accepted considerably fewer cases for investigation in 2006-07 than in 2005-06. There are two main reasons for this.

First, we have introduced a more robust process for deciding whether we could and, if so, whether we should accept a case for investigation. Our aim has been to ensure that our decisions to accept cases for investigation are correct in law, consistent, speedy and strategic – in line with the Ombudsman's role as a complaint handler of last resort.

Secondly, promoting better local complaints handling and resolution is one of our key objectives. Our assessment process therefore ensures that the body complained about has had an opportunity to resolve the

complaint. Also, where appropriate, we ensure that the complainant has made use of any appropriate second tier complaint handler, such as the Adjudicator or the Healthcare Commission.

Before we accept a case for investigation we want to be satisfied that:

- the complaint is properly within the Ombudsman's remit and the body complained about has not been able to resolve it;
- there is evidence of maladministration leading to un-remedied injustice;
- there is a reasonable prospect of a worthwhile outcome to our investigation.

We have also established a much clearer distinction between cases where we intervene to secure a positive outcome for a complainant without the need to launch an investigation, and cases where we investigate and report. Therefore, in future we will be able to report more accurately and comprehensively on those cases where our intervention short of an investigation has secured the resolution of a complaint, which is an important aspect of our work. Such cases are now recorded as concluded enquiries.

The figures in this Report show a substantial number of cases that were initially accepted for investigation but subsequently closed as an enquiry. This is because we reassessed all cases in hand when we adopted the assessment process described above. Subsequently, 373 cases were closed as enquiries rather than as investigations.

Overall, while the number of investigations has reduced, our overall workload remains substantially unchanged as more work is being done at the enquiry stage. The changes are more of presentation than of substance.

Restatement of workload in hand at 1 April 2006

The in hand figures for the number of investigations and the number of complaints about bodies quoted at 1 April 2006 in the 2005-06 Annual Report have been restated in some instances. This has arisen because of data quality issues, which have since been addressed by improving system controls, and partly because a small number of concluded investigations were reopened following a complaint about our decision.

Enquiries

We dealt with over 14,000 enquiries during the year. Of these, around 4,400 (31%) were requests for information and just over 9,800 (69%) were requests to investigate.

Of the requests to investigate:

- 17% were accepted for investigation
- 28% were not properly made (for example, not referred by an MP)
- 23% were premature
- 18% were out of remit
- 3% were withdrawn by the complaint
- In a further 11% of cases we decided not to investigate (for example, because there was no evidence of maladministration)

Figure 8 shows the number of enquiries received and closed. Figure 9 sets out the closure reasons.

Caseload

We began 2006-07 with 1,862 cases in hand. During the year we accepted a further 1,682 cases for investigation. Our output of completed cases of 2,927 in 2006/07 exceeded the number of cases accepted for investigation during the year by 1,245 and as a result the in hand figure reduced by 67% to 617. A summary is given in Figure 10. This year we placed

Figure 8
Number of enquiries received and closed in 2006-07

	In hand at 1.4.06 (restated)†	Received	Closed including those accepted for investigation	In hand at 1.4.07
Telephone	0	5,790	5,787	3
Email	7	2,145	2,132	20
Written	333	6,575	6,264	644
Total	**340**	**14,510**	**14,183**	**667**

† See above for an explanation of the restatement of 1 April 2006 figures

particular emphasis on reducing the number of in hand investigations that were over a year old, which resulted in a 69% reduction in the number of these cases from 234 to 73.

Customer service standards

Investigations over a year old have a significant 'drag factor' which affects our ability to meet the customer service standards we aspire to. As shown in Figure 11, we failed to meet these standards during the year. However, concluding a large

Figure 9
Number of types of closed enquiries 2006-07

	Infomation request	Not properly made	Out of remit	Premature – Health	Premature – Parliamentary	Discretionary decisions not to investigate	Withdrawn	Accepted	Total
Telephone	4,112	620	634	404	1	1	10	5	5,787
Email	148	993	579	389	1	5	2	15	2,132
Written	113	1,131	593	1,011	479	1,035	240	1,662	6,264
Total	**4,373**	**2,744**	**1,806**	**1,804**	**481**	**1,041**	**252**	**1,682**	**14,183**

Figure 10
Cases accepted for investigation and concluded in 2006-07

	In hand at 1.4.06 (restated)†	Accepted for investigation in year	Accepted but closed as an enquiry	Discontinued in the year	Reported on in the year	In hand at 1.4.07
Parliamentary – tax credits	314	120	15	1	393	25
Parliamentary – other	828	700	314	20	970	224
Parliamentary – total	**1,142**	**820**	**329**	**21**	**1,363**	**249**
Health – continuing care	199	239	7	9	352	70
Health – other	521	623	37	22	787	298
Health – total	**720**	**862**	**44**	**31**	**1,139**	**368**
PHSO – total	**1,862**	**1,682**	**373**	**52**	**2,502**	**617**

† See page 58 for an explanation of the restatement of 1 April 2006 figures

Figure 11
Performance against Customer Service Standards

Completion time from acceptance for investigation to report	Target	Health	Parliamentary	**Total**
Within 3 months	30%	17%	13%	**15%**
Within 6 months	60%	48%	38%	**43%**
Within 12 months	90%	80%	79%	**79%**

Figure 12
Outcome of complaints investigated 2006-07

	Upheld in full	Upheld in part	Not upheld	Total
Parliamentary – tax credits	30%	44%	26%	100%
Parliamentary – other	29%	29%	42%	100%
Parliamentary – total	**30%**	**33%**	**37%**	**100%**
Health – continuing care	72%	13%	15%	100%
Health – other	25%	27%	48%	100%
Health – total	**39%**	**23%**	**38%**	**100%**
PHSO – total	**34%**	**28%**	**38%**	**100%**

proportion of our older cases in 2006-07 has resulted in a significant decrease in the average age of investigations in hand at the year end (55% under 3 months old and 77% under 6 months old). This means we are in a strong position to improve on that performance in the year ahead.

Outcomes

Of the complaints we investigated in 2006-07, 34% were upheld in full (compared with 37% in 2005-06), 28% were upheld in part (30% in 2005-06) and 38% were not upheld (33% in 2005-06). A summary is given in Figure 12. The increase in the not upheld rate reflects the changing profile and nature of the complaints we reported on. For example, continuing care cases have high uphold rates. In 2005-06, these made up 33% of complaints reported on (pushing up the overall uphold rate), but in 2006-07 the proportion of continuing care cases had reduced to just 15% of complaints reported on. Detailed complaint outcomes, by body complained against, are included in the 'Government departments, agencies and public bodies' and 'The National Health Service' sections of this report.

Compliance with recommendations

All the recommendations we made during the year have been accepted or are currently being considered by the body or practitioner complained about. The majority of recommendations in our health investigations focused on an apology or some action to prevent a recurrence (for example, a review of or changes to procedures, or staff training). Others included action to remedy the failure identified, or

reconsideration of the decision. The majority of recommendations in our Parliamentary investigations focused on financial compensation for inconvenience or distress. Others included an apology, financial compensation for loss or an action to remedy the failure identified.

Freedom of Information and Data Protection requests

During the year, we received over 250 requests for information under the Freedom of Information Act or the Data Protection Act. These were either from members of the public, requesting information about our procedures and statistics, or from complainants or their representatives seeking copies of information from their files. We did not always meet the statutory timescales for responding to requests.

Responding to these requests presents difficulties for the Ombudsman. This is mainly because of the interaction between the Freedom of Information and Data Protection Acts and the Ombudsman's powers as set out in the Parliamentary Commissioner for Administration Act 1967 and the Health Service Commissioners Act 1993.

A project is underway to look at how best we can approach the Freedom of Information and Data Protection Acts and we have been discussing with the Information Commissioner's Office how we can reconcile these issues. In the meantime, our current Publication Scheme is available on our website, www.ombudsman.org.uk, and contains a wide range of information about our work.

"Being accountable for our performance is important to us."

Managing our resources

The Parliamentary and Health Service Ombudsman's full Resource Accounts 2006-07 were laid before Parliament on 18 July 2007 and are available on our website at www.ombudsman.org.uk or from The Stationery Office.

Summary Financial Statements for the year ended 31 March 2007

Statement of the Parliamentary and Health Service Ombudsman

The following Financial Statements are a summary of information extracted from PHSO's full annual accounts for 2006-07, which were signed by the Ombudsman on 26 June 2007. While the summary below does not contain sufficient detail to allow for a full understanding of the financial affairs of the PHSO, they are consistent with the full annual accounts and auditor's report, which should be consulted for further information.

The Comptroller and Auditor General, who has been appointed by the Parliamentary and Health Service Ombudsman as auditor, has given an unqualified audit opinion on the PHSO's Resource Accounts.

Ann Abraham
Parliamentary and Health Service Ombudsman

Statement of the Comptroller and Auditor General to the House of Parliament

I have examined the Summary Financial Statement of the Parliamentary and Health Service Ombudsman comprising a summary financial review, resource outturn, operating cost and cash flow statements for the year ended 31 March 2007 and a summary balance sheet at that date.

The Ombudsman is responsible for preparing the Summary Financial Statement. My responsibility is to report to you my opinion on its preparation and consistency with the full Resource Accounts.

I have conducted my work in accordance with Audit Bulletin 1999-06, "The auditors' statement on the summary financial statement", issued by the Auditing Practices Board. My certificate on the full accounts of the Parliamentary and Health Service Ombudsman describes the basis of my opinion on those accounts. I have also read the other information contained in the Annual Report to the accounts and considered the implications for my opinion if I become aware of any apparent misstatements or material inconsistencies with the Summary Financial Statement.

In my opinion the Summary Financial Statement is consistent with the full Resource Accounts of the Parliamentary and Health Service Ombudsman for the year ended 31 March 2007.

Sir John Bourn
Comptroller and Auditor General

Financial Review

PHSO's net operating cost for 2006-07 was £22,853k, comprising expenditure of £23,222k spent in carrying out its activities offset by operating income of £369k. Excluding £5k income that must be surrendered to the Exchequer, and £179k funding from the Consolidated Fund for the salary and on-costs of the Ombudsman, PHSO's net total resource requirement for the year was £22,679k, which was an underspend of £962k (4.1%) of PHSO's 2006-07 funding as approved by Parliament. The reasons for this underspend were:

- retention of an unutilised contingency reserve of £150k;
- a reduction of £360k in our costs following the rationalisation of our accommodation requirements;
- lower than expected costs arising from the annual revaluation of our fixed assets; and
- reduced depreciation charges arising from the deferment of the accommodation project into 2006-07 from 2005-06.

Capital investment expenditure for the year was £4,958k, mainly utilised on our accommodation refurbishment project. This was a marginal underspend against the £4,994k funding approved by Parliament for 2006-07.

PHSO's General Fund reserve has increased by £4,393k, which mainly reflects the increased value of our asset base as a result of the capitalisation of the costs of our accommodation refurbishment project.

Summary of Resource Outturn 2006-07

	2006-07						2005-06	
	Estimate			Outturn				
	Gross expenditure	A in A	Net total	Gross expenditure	A in A	Net total	Net total outturn compared to estimate: saving/(excess)	Outturn
	£000	£000	£000	£000	£000	£000	£000	£000
Request for resources	24,047	406	23,641	23,043	364	22,679	962	22,263
Total resources	**24,047**	**406**	**23,641**	**23,043**	**364**	**22,679**	**962**	**22,263**
Non operating cost A in A	–	5	(5)	–	–	–	(5)	–

PHSO's net cash requirement for the year of £26,889k was within our cash financing limit of £27,650 as approved by Parliament.

Operating Cost Statement for the year ended 31 March 2007

	2006-07 £000	2005-06 £000
Administration costs:		
Staff costs	13,458	12,907
Other admin costs	9,764	9,840
Gross administration costs	**23,222**	**22,747**
Operating income	(369)	(402)
Net administration costs	**22,853**	**22,345**
Net operating cost	**22,853**	**22,345**
Net resource outturn	**22,679**	**22,236**

Balance Sheet as at 31 March 2007

	31 March 2007		31 March 2006	
	£000	£000	£000	£000
Fixed Assets:				
Tangible assets		6,354		2,594
Intangible assets		638		821
		6,992		3,415
Current assets:				
Debtors	968		1,237	
Cash at bank and in hand	391		178	
	1,359		1,415	
Creditors (amounts falling due within one year)	(1,597)		(1,929)	
Net current liabilities		(238)		(514)
Total assets less current liabilities		6,754		2,901
Creditors (amounts falling due after more than one year)	(825)		(999)	
Provisions for liabilities and charges	(844)		(1,218)	
		(1,669)		(2,217)
		5,085		**684**
Taxpayers' equity				
General Fund		4,709		316
Revaluation Reserve		376		368
		5,085		684

Cash flow statement for the year ended 31 March 2007

	2006-07 £000	2005-06 £000
Net cash outflow from operating activities	(22,110)	(22,138)
Capital expenditure and financial investment	(4,958)	(1,500)
Payments of amounts due to the Consolidated Fund	(68)	(44)
Financing	27,349	23,349
Increase/(decrease) in cash in the period	**213**	**(333)**

The Board as at March 2007

Ann Abraham
Parliamentary and Health Service Ombudsman

Trish Longdon
Deputy Ombudsman

Bill Richardson
Deputy Chief Executive

Philip Aylett
Director of Strategy and Communications (Policy Information and Communications from 1 April 2007)

Linda Charlton
Director of Equality and Diversity (left on 30 March 2007)

Andrew Puddephatt OBE
Audit Committee Chair

Tony Redmond
External Board Member

Cecilia Wells OBE
External Board Member

Annex A:

Governance

The post of Parliamentary and Health Service Ombudsman combines the two statutory roles of Parliamentary Commissioner for Administration and Health Service Commissioner for England.[8] The Ombudsman is solely responsible and accountable for the conduct and administration of all work carried out by this Office and for the decisions made in each case.

The PHSO Advisory Board

The Ombudsman appointed a non-statutory Advisory Board in 2004 to reinforce the governance of this Office. During 2006-07, this comprised the Ombudsman (as Chair and Chief Executive in line with her statutory accountability), two non-executive members, who bring an external perspective to our work, and four executive officials: the Deputy Ombudsman, Deputy Chief Executive, Director of Strategy and Communications and Director of Equality and Diversity.

During 2006-07, the Ombudsman decided to appoint two additional external members to bring in-depth knowledge of organisational development/change management and communications/marketing. The new appointments were made through a process of fair and open competition and the appointees took up their posts on 1 April 2007. From that date, members of the Executive Board normally attend Advisory Board meetings, but are not members.

The role of the Advisory Board is to provide support and advice to the Ombudsman in providing leadership and good governance, as set out in the Office's Governance Statement[9]. Its external perspective assists in the development of policy and practice. The Advisory Board provides specific advice and support on:

- Purpose, vision and values;
- Strategic direction and planning;
- Accountability to stakeholders, including stewardship of public funds; and
- Internal control arrangements and risk management arrangements.

The Advisory Board has two formal sub-committees, an Audit Committee and a Pay Committee, which have key roles in supporting the effective governance of this Office.

The Executive Board

The Executive Board is chaired by the Ombudsman and included in 2006-07 the Deputy Ombudsman, Deputy Chief Executive, the Director of Strategy and Communications and the Director of Equality and Diversity. The Executive Board manages the Office's functions and activities and is responsible for the delivery of our strategic vision, policies and services to the public and other stakeholders.

The Director of Equality and Diversity left the Office on 30 March 2007. She has been appointed a member of the Advisory Board from 1 April 2007.

The Ombudsman carried out a restructuring during 2006-07 to align the Office's internal organisation more closely with the business process and to join up related functions more effectively.

[8] The Ombudsman's powers are set out in the Parliamentary Commissioner Act 1967 and the Health Service Commissioners Act 1993.

[9] The full Governance Statement is available at www.ombudsman.org.uk/about_us/governance/governance_statement.html.


Ombudsman
Ann Abraham
Deputy Ombudsman
Trish Longdon
Deputy Chief Executive
Bill Richardson
Director of Strategy & Communications
Philip Aylett
Director of Diversity & Equality
Linda Charlton
(left on 30 March 2007)
Operations
Investigation Directors
Carole Auchterlonie
Christine Corrigan
Valerie Harrison
Jack Kellett
Hilary York
Clinical Advice Director
Susan Lowson
Head of Gateway
Damian Brady
Corporate Resources
Finance Director
Graham Payne
Human Resources Director
Jon Ward
Service Delivery Director
Mark Castle-Smith
Legal Adviser
Anne Harding

Annex B:

Strategic Plan objectives 2007-10

Our aims and objectives for 2007-10 are:

Aim

To deliver a high quality complaints handling service to customers.

Objectives

To deliver a high quality service based on understanding our customers' needs and making our service accessible to all who need it.

To maintain a high quality service by anticipating the impact of changes in customers' needs and public service policy and developing our capacity to respond.

To operate a high quality service by developing high performing staff and getting the best from our resources.

Aim

To contribute to improvements in public service delivery by being an influential organisation, sharing our knowledge and expertise.

Objectives

To establish a distinct and recognised role in the administrative justice landscape and regulatory environment.

To be recognised and utilised by others as a source of expertise in good administration and complaint handling.

To be an authoritative voice on delivering systemic change, actively sought out by others.

Three core priorities drive our work:

- Continuously improving the **quality** of our service;
- Increasing the **efficiency** of all aspects of our core activities;
- Extending our **influence** with others to help improve public service delivery.

About the Parliamentary and Health Service Ombudsman

The Parliamentary Ombudsman

carries out independent investigations into complaints that government departments and a range of other public bodies in the UK have not acted properly or fairly or have provided a poor service.

The Health Service Ombudsman for England

undertakes independent investigations into complaints made by, or on behalf of, people who have suffered because of poor treatment or service provided through the NHS.

The Parliamentary and Health Service Ombudsman is completely independent of the Government, the Civil Service and the National Health Service. The Ombudsman's services are available to everyone and are free of charge.

To find out more, visit our website www.ombudsman.org.uk or contact our Helpline on 0845 015 4033 to ask for information or to request a leaflet.

You can also write to us at the address below or email us at phso.enquiries@ombudsman.org.uk

Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London
SW1P 4QP

Printed in the UK for The Stationery Office Limited on behalf of the Controller of Her Majesty's Stationery Office

ID5598413 07/07

Printed on 100% recycled paper

Design and production www.dtw.co.uk

Millbank Tower
Millbank
London SW1P 4QP

Telephone 0845 015 4033
Fax 020 7217 4000

Email
phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

Published by TSO (The Stationery Office) and available from:

Online

www.tsoshop.co.uk

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich, NR3 1GN
Telephone orders/General enquiries: 0870 600 5522
Order through the Parliamentary Hotline Lo-call 0845 7 023474
Fax orders: 0870 600 5533
E-mail: customer.services@tso.co.uk
Textphone 0870 240 3701

TSO Shops
16 Arthur Street, Belfast BT1 4GD
028 9023 8451 Fax 028 9023 5401
71 Lothian Road, Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

The Parliamentary Bookshop
12 Bridge Street, Parliament Square,
London SW1A 2JX
Telephone orders/General enquiries 020 7219 3890
Fax Orders 020 7219 3866
Email bookshop@Parliament.uk
Internet bookshop.Parliament.uk

TSO@Blackwell and other Accredited Agents

ISBN 978-0-10-294613-0

9 780102 946130