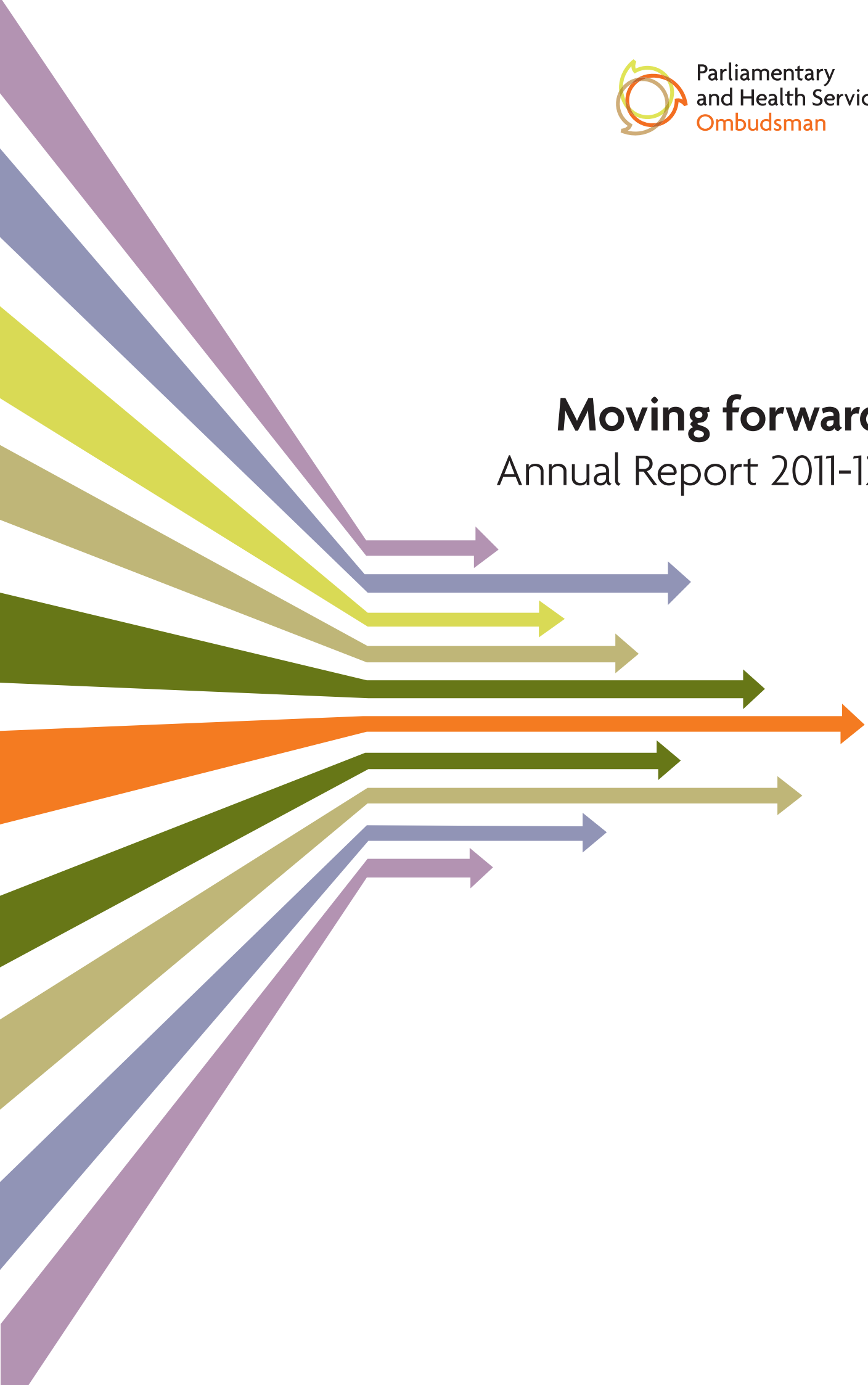
Parliamentary and Health Service Ombudsman

Moving forward

Annual Report 2011-12



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Annual Report 2011-12

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Contents

Foreword by Dame Julie Mellor, DBE

This report, my first as Parliamentary and Health Service Ombudsman, describes the work of a precious public institution – one that has the independence and authority to intervene when the state fails the public and which works to put things right for individuals when all other attempts have failed.

As the following pages reveal, last year was one of our busiest yet and we successfully resolved more complaints for individuals either through formal investigation or via quicker, simpler means. We published reports on issues as wide-ranging as the internment of a family by the Japanese during the Second World War and the failings in care for a man with Down's syndrome, who was wrongly placed in locked accommodation until his death. We promoted our concerns about GPs striking patients off their lists unfairly and highlighted the complexity of the differing complaints procedures operated by government departments.

There is more to do and throughout this report you can read how our future plans are taking shape. Moving forward, we want to deliver more impact for more people, by raising our profile and making it easier for people to complain. We want to build our relationship with Parliament by sharing more learning from our casework and by supporting MPs in tackling issues where the state has failed individuals, communities or the public. Alongside this, we will continue to improve the service we offer to individuals by acting as a fair and impartial complaint handler of last resort.

My thanks go to my predecessor, Ann Abraham, who left behind a well-run organisation with strong foundations on which we can build for the future. Staff across our two sites have given me a warm welcome. Together, we are committed to using our independence, authority and expertise to provide more impact for more people in future.

The new Ombudsman

Dame Julie Mellor, DBE has 30 years' experience of public services and business. Her roles have included the Chair of the Equal Opportunities Commission, where she was consistently rated among the top 25 opinion formers in the public sector. She was Human Resources Director for British Gas and a Board Member of the National Consumer Council.

As a partner in PricewaterhouseCoopers' health sector team, she founded the innovative Forward Thinking programme, which works with politicians, think tanks and public sector opinion formers to contribute expertise and ideas to solve big public sector challenges.

A genuine representative of the people she served

When Ann Abraham retired in January 2012 she left behind a valuable and lasting legacy. She undertook the role of Ombudsman with great commitment, independence and integrity, and worked tirelessly to tackle injustice. Bernard Jenkin MP, Chair of the Public Administration Select Committee, said Ann was someone who had *'changed the course of history'* on the question of Equitable Life and on many other issues of importance to individuals. Another member of the Committee, Kelvin Hopkins MP, said: *'Ann Abraham was always first class. She was steadfast, highly intelligent, a genuine representative of the people she served, and loyal to Parliament.'*

Our role, vision and values

Our role

We consider 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

To provide an independent, high quality complaint handling service that rights individual wrongs, drives improvements in public services and informs public policy.

Our values

Our values shape our behaviour, both as an organisation and as individuals, and incorporate the *Ombudsman's Principles*.

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 people so that they can provide an excellent service.

Leadership

We lead by example so that our work will have a positive impact:

- we set high standards for ourselves and others
- we are an exemplar and provide expert advice in complaint 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.

Key facts about us

From families struggling on low incomes to farmers frustrated by bureaucracy, from the carers of elderly parents to women seeking fertility treatment, we help put things right for individuals and communities when public services fail them.

Our service is independent, impartial and free to use.

In 2011-12 we looked closely at 4,732 enquiries, conducted 410 investigations and secured over 1,700 remedies.

The Ombudsman is Dame Julie Mellor, DBE, who took up post on 3 January 2012. Her predecessor was Ann Abraham.

Our budget is £33m, funded by the taxpayer.

We are accountable to Parliament via the Public Administration Select Committee.

We have 422 full time equivalent staff in two locations: London and Manchester.

Our year at a glance

June 2011

In a report detailing the failure of a dentist to apologise, we warned of the seriousness of ignoring recommendations arising from NHS complaints.

July 2011

Working jointly with the Local Government Ombudsman, we revealed how a vulnerable adult was let down by the NHS trust and council responsible for his care.

August 2011

We continued our partnership with the South African Public Protector, learning about their approach to equality and diversity and how they communicate with communities that are hard to reach.

September 2011

The Government was told to *'hang its head in shame'* after our report highlighted the repeated failings of the Ministry of Defence to treat fairly a family who were interned by the Japanese during the Second World War. (See page 18)

October 2011

'Patchy and slow' is how we described the progress the NHS is making to improve the way it deals with patients' complaints. (See page 22)

Our review *Responsive and Accountable?* uncovered the lengthy and protracted complaint systems in some government departments and agencies. (See page 22)

November 2011

The overwhelming majority of respondents to our public consultation on direct access supported the removal of the MP filter for complaints about government departments and agencies. (See page 26)

By joining forces with the Local Government Ombudsman, we uncovered significant failings in the care provided by an NHS trust and local Council to a man with Down's syndrome.

In *More Cold Comfort* we told the stories of nine farmers who, amid the confusion of a new system, had made innocent mistakes in their claims for financial support. Our investigation secured compensation for those individuals and a commitment from the Rural Payments Agency to make changes to prevent future problems. (See page 18)

We gave evidence to the Commission led by the NHS Confederation on why and how older people's care is failing on dignity and what will drive improvement. (See page 19)

January 2012

We said farewell to Ann Abraham and welcomed her successor, Dame Julie Mellor, DBE who became the ninth Ombudsman.

March 2012

The Health and Social Care Bill received Royal Assent, introducing new powers for us to share our decisions on NHS complaints more widely. (See page 32)

Our casework in 2011-12

In 2011-12 we received 23,846 enquiries from the public and continued work on 1,400 carried over from 2010-11.

What people contacted us about

2,794
Organisations not within our jurisdiction

6,437
Government departments and agencies

14,615
NHS

How we helped

We resolved 23,889 enquiries. We provided help and advice on 19,157 of these and looked closely at 4,732.

3,298
Advice on the right organisation to complain to

15,859
Help with making a complaint to an organisation within our jurisdiction, or to us

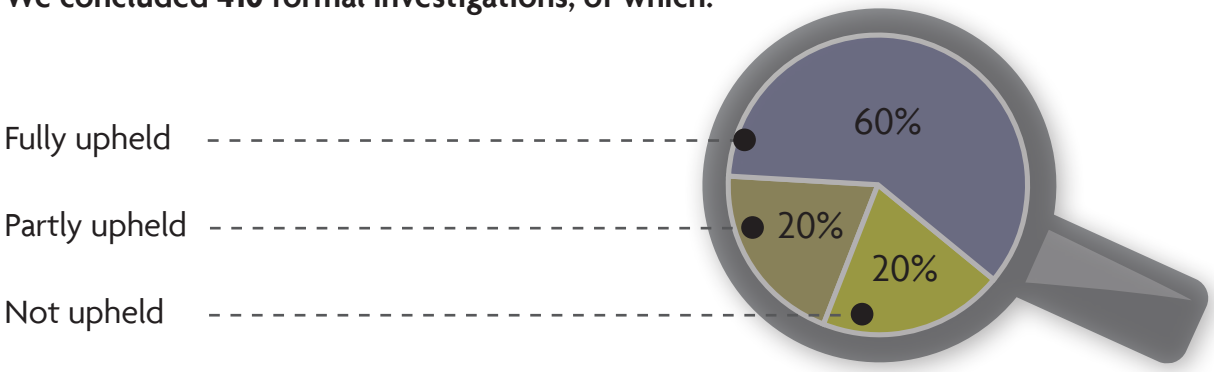
Of the 4,732 enquiries we looked closely at:

3,552 We found there was no case to answer

759 We put things right quickly without the need for a formal investigation

421 We accepted the case for formal investigation

We concluded 410 formal investigations, of which:



Where something had gone wrong, our work led to:

591 Apologies

531 Compensation payments

404 Wider remedies

204 Actions to put things right

We carried over 1,357 enquiries and 332 investigations into 2012-13.

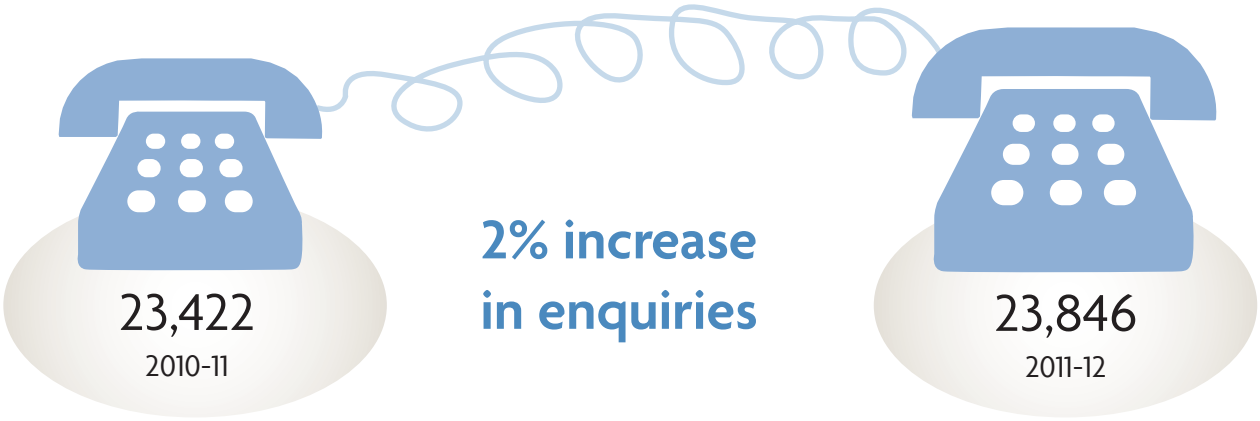
For more information see the appendix at page 44 and our *Resource Accounts 2011-12*.

Delivering for individuals

Public organisations make decisions daily that affect family incomes, healthcare, jobs, businesses and much more. Resolving individual complaints about public services is at the heart of what we do.

When things have gone wrong, our work helps individuals by providing them with answers or explanations or getting things put right so they can move on with their lives.

In 2011-12 we examined 4,732 cases, concluded 410 investigations, and secured over 1,700 remedies for individuals.



First contact

Last year, more people than ever before contacted us asking for help with their complaint.

When anyone contacts us there are a few things that we need to check. Before we can look at a complaint more closely, we ask:

- is it about an organisation and a subject that we can look into? and
- has there been a complaint to that organisation and have they had the opportunity to put things right?

Last year, we could answer 'yes', to the above questions in only 26% of the enquiries made to us.

By law, we also have to ensure that the complaint is made to us in writing (if about the NHS) or passed to us by an MP (if about a government department or agency).

We do all we can to point those we cannot help in the right direction. If their enquiry is about an organisation or a subject that we cannot look into, we will help them put their enquiry to the right complaint handler. If they have not met the legal requirements, we will help them do so.

Quite often the enquiries we receive are about complaints that have become stuck in the system. In those cases we will give advice on how to progress it, often contacting the organisation directly to get things moving.

Moving forward

We want to make it easier for people to find out how to complain about public services and to help make sure their complaint reaches the right place.

Providing a voice

Mr R contacted us because he needed to speak to Jobcentre Plus about the recovery of an overpayment of benefits to his wife. Mrs R, who is deaf, had problems communicating with Jobcentre Plus by telephone and she was unable to answer the security questions enabling them to talk to her husband instead. Providing Jobcentre Plus with written consent would take time, but Mr and Mrs R faced immediate hardship. We spoke to Jobcentre Plus who told us that they would suspend recovery of the overpayment while the couple were appealing against it. More importantly, they would speak with Mr R on his wife's behalf.

A closer look

Once we have checked that a complaint may be one we can help with, we take a closer look to see if something has gone wrong and not been put right. This can include talking to the complainant and the organisation complained about, reviewing the papers, and, sometimes, seeking expert advice.

In 3,552 cases, our closer look showed either no evidence that something had gone wrong, or that something had gone wrong but it had already been put right. In each of these cases where we were satisfied that there was no case to answer, we explained the reasons for our decision, including any professional or clinical advice we had relied on.

I am grateful to you for providing the necessary redress and feel we can go forward in the hope that patients will be better served in future.

One of our customers

Putting things right quickly

In 759 cases it was clear that something had gone wrong and our intervention helped put things right quickly. In 491 of those cases, we worked with the organisation complained about to sort out the problem. This is a growing area of our work and the number of cases we resolve this way has increased by 48% since last year.

In 268 cases we put things right ourselves. Most of these were NHS complaints where something had gone wrong and the organisation complained about had failed to explain properly what happened. With the help of our expert clinical advisers, we provided the complainant with a fuller explanation.

Moving forward

Working this way is speedy and effective. It sorts things out quickly for individuals, and can result in an apology, compensation or action to make sure the problem does not happen again. We want to find more ways to resolve complaints quickly for our customers.

I wasn't made to feel like a statistic and felt they were fighting on my behalf to reveal the truth.

One of our customers

Formal investigations

Sometimes a closer look at a complaint shows that the issues involved are particularly complex or hard to solve. At other times, the complaint raises significant issues or indicates that there may be wider problems. In such cases we will usually decide to conduct a formal investigation. The findings of our investigations can be reported to Parliament, sharing the issues at the heart of the complaint and the learning more widely, and contributing to public debate on important matters.

During 2011-12 we accepted 421 cases for investigation and concluded 410. Of those accepted for investigation, 93 cases covering 118 complaints were about government departments or agencies and 328 cases covering 400 complaints were about the NHS. We upheld in full or in part 79% of the complaints investigated about the NHS and 83% of complaints about government departments and agencies.

Remedies

Where we find that things have gone wrong, we focus on putting the complainant back in the position he or she would have been in before the mistake occurred. In nearly all cases this means getting the organisation to take action to put matters right. Sometimes this means offering an apology and an explanation, and in others it may involve financial remedy. But we also have the ability to get beyond the individual complaint, to spot themes and trends, and to make recommendations for change that will have an impact not just for the individual but also for the whole community.

As our published reports have shown time and time again, our investigation of one complaint can have big consequences for the way in which public services are delivered.

In 2011-12 we sought 1,730 remedies, all of which have been accepted by the organisation complained about or are under consideration.

Moving forward

We want to work in partnership with others to spot potential problems or failures in public services so that we can investigate and put right issues affecting large numbers of people.

We take heart that the scope of the changes implemented will benefit others.

One of our customers

Treating a vulnerable patient fairly

When Mr S, who has learning difficulties, tried to register with a local GP practice his application was refused. Shortly afterwards, two GP surgeries asked the Primary Care Trust to register Mr S on a scheme for violent patients.

Mr S, who spent over two years on the scheme, was distressed by being labelled as violent. He complained to the Trust that he had been wrongly placed on the scheme, that he had not been told why this had happened and that he had not been given the opportunity to challenge the decision. When the Trust responded that his placement on the scheme was correct, he complained to us.

We were able to put things right for Mr S without the need for a formal investigation. Our enquiries showed that there was no evidence that Mr S had ever made a threat of violence. Alongside this, doctors who knew Mr S had said that he did not belong on the scheme and that he had been placed on it because of a lack of alternatives to meet his needs.

We agreed with Mr S that the decision to place him on the scheme was wrong. We discussed this with the Trust and they agreed to apologise to Mr S, and pay him £2,000 in compensation. They also made changes to the scheme to prevent the same situation happening again.

Investigation leads to change of Ofsted policy

Like many other businesses, childcare providers rely on a good local reputation for their livelihoods. When Ms F, a nursery owner in a small town in Kent, discovered that Ofsted (the Office for Standards in Education, Children's Services and Skills) had made mistakes in the report on their inspection of her nursery, she asked them to put them right. Instead, Ofsted published the report on their website. They later declared the report null and void but not in time to prevent damage to Ms F's business. Distressed, angry and embarrassed, Ms F contacted us asking for help.

We do not expect organisations to suspend their legal duties to publish decisions simply because someone makes a complaint. We do expect them to have mechanisms in place to ensure that those decisions are robust. This is vital when the potential consequences of publishing a report that might be unsafe are so great.

Ofsted accepted all of our recommendations for remedy. They apologised and compensated Ms F for financial loss and interest on the money she borrowed to keep her business going during the period in question. They also agreed to review their policy on publishing reports that are disputed, and to notify parties if a report has been withdrawn.

> *At least some good has come from this sorry state of affairs.*
>
> One of our customers

The government departments with the most complaints accepted for formal investigation were:

Ministry of Justice	**29**
including HM Courts & Tribunals Service	14
Home Office	**24**
including UK Border Agency	22
Department for Work and Pensions	**20**
including the Independent Case Examiner	9
HM Revenue & Customs	**14**
including the Adjudicator's Office	6
Department for Communities and Local Government	**8**
including the Planning Inspectorate	7

The health bodies with the most complaints accepted for formal investigation were:

NHS hospital, specialist and teaching trusts (acute)	222
General practitioners	82
Primary care trusts	28
Mental health, social care and learning disability trusts	26
General dental practitioners	16

Delivering for the public

Our work to resolve complaints for individuals gives us information and learning that we can use to help improve public services for the benefit of everyone.

Alerting Parliament to injustice

We presented Parliament with nine reports, all highlighting the injustice caused to individuals by the actions of public organisations – injustice that was often made worse by the inability or refusal of those organisations to put matters right when they had an early opportunity to do so.

In September 2011 the Government was told to *'hang its head in shame'* after our report *Defending the Indefensible* highlighted repeated failings by the Ministry of Defence to treat fairly a family who were interned by the Japanese during the Second World War. Alerting Parliament to her concerns, Ann Abraham described it as: *'The worst example I have seen, in nearly nine years ... of a government department getting things wrong and then repeatedly failing to put things right or learn from its mistakes.'* She said that her report should be required reading for every aspiring senior civil servant.

A different investigation into the Rural Payments Agency's (part of the Department for Environment, Food and Rural Affairs) administration of a farmers' subsidy scheme found that farmers had missed out on payments they were entitled to. Ann Abraham told Parliament that this was the second time she had investigated poor administration of the scheme. Although the new report told a similar story of poor administration, she wrote that: *'... the response from the Rural Payments Agency and Defra has been a very different one this time, and I am pleased that my recommendations have been accepted in full.'*

On two occasions we reported on our work with the Local Government Ombudsman. Both reports alerted Parliament to the human consequences of the lack of integration in health and social care. The first joint report highlighted failings in care for a vulnerable adult in Merseyside, while the second revealed how a man in Newcastle with Down's syndrome was detained unnecessarily in hospital and was then moved into inappropriate locked accommodation until his death.

Improving care for older people

Our report into the care of older people by the NHS, *Care and compassion?*, published in February 2011, generated a huge response from patients, carers, the press and health professionals and we have continued to be a key player in the debate that followed.

In November we gave evidence to the Commission on Improving Dignity in Care for Older People. That Commission was set up by the NHS Confederation, Age UK and the Local Government Association in direct response to our report. In an interview with *The Guardian* (February 2012), NHS Confederation Chair, Sir Keith Pearson, said: *'I can remember when the report landed. ... We took the view that this was a hugely important document. It said something about the NHS that was deeply shocking. When you read the report, then read it for a second time, it resonated with every one of us. It described something we knew was wrong. So we took a decision to do something different. And that meant we had to hold the feet of the NHS to the fire and say this is not good enough.'*

The Commission has now presented its final report, *Delivering Dignity*, which calls for a *'major cultural shift'* to tackle the underlying causes of poor and undignified care of older people throughout care homes and hospitals in England. Dame Julie Mellor, DBE welcomed that report, urging the NHS to consider how to use feedback from complaints to improve services and the experience of patients.

Sharing our learning and expertise

During the year we visited over 50 NHS providers to share learning from complaints. We used these visits to discuss information about the numbers and types of complaints brought to us about their services, and to understand what they are doing locally to resolve more complaints without the need for our involvement. We also used the opportunity to suggest areas for improvement and to assure ourselves that they are addressing any patterns emerging in complaints to us.

We shared our learning expertise on a national level too. In June 2011 Ann Abraham gave evidence on the NHS complaints procedure to the public inquiry into the Mid-Staffordshire NHS Foundation Trust.

Also, we shared our expertise in good administration and our learning from casework with key stakeholders by responding to a number of consultations throughout the year. These include consultations by the Law Commission, the Department of Health, the Care Quality Commission, Monitor, the General Medical Council, the Department for Work and Pensions, the Equality and Human Rights Commission and the Cabinet Office.

Moving forward

We want to do more to use the lessons learnt from complaints to work with Parliament, regulators, public service providers and others to help improve public service delivery.

Changing the way personal data is handled

The way individuals' personal information is handled by public organisations is high on the public agenda and we have helped to improve standards in this area. Last year our report, *A Breach of Confidence*, described how a number of government agencies refused to accept responsibility for the mishandling of Ms M's personal information on their computer systems, despite their actions having personal and financial implications for Ms M. The Cabinet Office responded to our findings and recommendations by developing a protocol for all government departments to use when they are sharing personal data.

The government agencies involved also implemented a protocol on handling complaints that cut across the work of their departments.

But the story doesn't stop there. Following our report, as one of the named departments, HM Revenue & Customs (HMRC) also undertook a thorough 'after action review'. The review identified key learning points. These included the importance of maintaining the integrity and security of personal information when it is shared across departments, and the need to ensure the safe transfer of any security markings. HMRC presented the learning to a meeting of cross-government complaint handlers.

Driving improvements in complaint handling

Our work to resolve complaints for individuals often shows how, when something has gone wrong, poor complaint handling by organisations can make matters worse. Using evidence from our casework, we published separate reports on the complaint handling systems across government and the NHS.

In our report, *Responsive and Accountable?*, we included a survey of complaint handling by government departments and agencies that revealed varying systems, with members of the public being required to navigate anything between one and four stages of a local complaints procedure before they could bring their complaint to us.

Our health report, *Listening and Learning*, focused on two themes; the unfair removal of patients from GPs' lists and poor communication.

Following the publication of the reports, we hosted meetings of complaint handlers from across both government and the NHS to share the key messages from the reports and to ensure that learning from our casework filtered down.

All of our published reports are available on our website at www.ombudsman.org.uk.

Moving forward

We want to use our expertise to help the government and the NHS handle complaints better.

Investigation results in better care for others

Mr and Mrs B complained to us about the care given to Mrs B's sister, Mrs A, who had Alzheimer's disease. They didn't want an apology – simply an acknowledgement of the Trust's failings and the injustice caused. Our investigation secured that and also led to a 16-point action plan by the Trust which will improve the care of future patients and benefit the wider community.

Mrs A was living with Mr and Mrs B when she was admitted to hospital with a chest infection. She was fed by a tube through her nose and into the stomach, but she sometimes pulled this out. Twice after doing this Mrs A went without food while staff waited for X-ray results. On one occasion she vomited constantly and it was five hours before staff intervened. This was undignified and threatened her life. On another occasion, when a scan was abandoned because Mrs A could not lie still, nobody reassured her, or spoke to her in her native language.

When the decision to stop actively treating Mrs A, who by then was dying, was taken nobody from Croydon Health Services NHS Trust discussed that with Mr and Mrs B. Mr and Mrs B chose to care for Mrs A at home but were given no support or information about how to do this.

Following our investigation, the Trust drew up an action plan to prevent a repeat of the failures we had identified, including the monitoring of staffing levels for all inpatient areas to prevent delays in providing care. They also planned ways to improve nursing staff support and communications with patients and carers. These ranged from giving patients adequate information about the drugs they take home with them to ensuring that there is a clear point of contact for families. Also, the Trust took action to improve the care given to patients, through training and reminders about the standards nurses are expected to meet.

Our service

With complaints at the heart of our work, we aim to deliver an independent, high quality and accessible service to those who need us.

Independent

Our independence from the NHS and government enables us to look at complaints without taking sides. Our processes are designed so that our consideration of complaints is robust, balanced and fair to everyone involved. We use the *Ombudsman's Principles* to help establish a clear understanding about what should have happened in each complaint. The *Principles* are broad statements of what we consider public services should do to deliver good administration and customer service, and how they should respond when things go wrong.

In November 2011 our approach to resolving complaints about poor service provided to people with disabilities was tested in the High Court as the result of a legal challenge by Mencap. The judge ruled that our approach produced *'useful and lawful investigations'* and said that without our investigations, many complaints could only be determined, if at all, by the courts, which would be unlikely to be welcome to complainants.

High quality

Our latest customer survey shows 71% of people surveyed when they first contacted us were satisfied with our service and the information and advice that we gave them. Of those whose complaint we investigated, 82% were satisfied with our service.

For most people coming to us, our decision is the last opportunity to get things put right. We have built several checks and balances into our processes to ensure that our decisions are fair and robust. We give serious consideration to any complaints raised by our customers about our decisions and we seek to use the learning from these to improve our performance. In 2011-12 we found that 0.4% of our decisions needed to be looked at again or required further explanation.

Cases that had been with us for 12 months or more

We resolve complaints as quickly as possible and met five of the six customer service standards we set ourselves.

In 2011-12 we worked hard to resolve some of our toughest, most complicated, and longstanding complaints. By the end of the year we had only 20 cases in hand that had been with us for 12 months or more.

Clearing these older cases meant we fell short of concluding 90% of investigations within 12 months. Our performance was 79%. It also resulted in an increase in the average length of time it took to close an investigation from 323 to 357 days. However, of the 332 investigations in hand as at 31 March 2012 the average age was 152 days.

Accessible

In June 2011 Parliament's Health Committee published their *Complaints and Litigation* report, highlighting lessons for the NHS, government and us. The Committee recommended that we look again at the way we describe our work to complainants and the public in order to build greater understanding of, and confidence in, our work. We value the feedback they, and others, have given us and are reviewing the language we use in our letters and reports to make them easier to read and understand.

Meeting our customer service standards

- ✓ Acknowledge 100% of email enquiries within 1 working day
- ✓ Acknowledge 100% of written enquiries within 2 working days
- ✓ Close 90% of enquiries within 40 working days
- ✗ Conclude 90% of investigations within 12 months
- ✓ Acknowledge 95% of complaints about us within 5 working days
- ✓ Resolve 90% of complaints about us within 16 weeks

Last year, we launched Facebook and Twitter accounts and a LinkedIn profile, which gave us new ways to share information with different communities about our work. And, for those who prefer to contact us in a language other than English, we increased our use of translation and telephone interpreting services.

There are, however, certain obstacles to access that we simply cannot overcome without the support and actions of government and Parliament.

By law, before we can look closely at an individual's complaint about a government department or agency, it has to be passed to us by an MP. In 2011-12 we were unable to look more closely at 329 enquiries because they did not meet this requirement.

Throughout the summer of 2011 we consulted on our view that members of the public should be able to bring their complaints to us directly. We found that there was strong support for a 'dual track' approach. This would allow complainants the option of making a complaint through an MP or coming to us directly. It would open up access for the individual whilst maintaining the important role MPs play in supporting their constituents.

Building a diverse workforce

We want to improve the diversity of our workforce at all levels, to reflect the community we serve. We take positive action, where appropriate, to improve workforce diversity. Last year we piloted an upward mentoring scheme to develop junior black and minority ethnic staff and to provide our senior managers with new insights into their leadership style.

We also commissioned a disability confidence development programme from Disability Rights UK to improve the way we manage disability internally and to equip us better to deliver the best possible service to our customers with a disability.

We monitor our workforce profile against benchmarks of the economically active populations at our two sites in London and Manchester.

We publish our equality and diversity information on our website at www.ombudsman.org.uk.

Moving forward

We have more to do to achieve our aim of being an exemplar organisation in equality and diversity. We will place equality and diversity at the heart of our work to refresh our new strategy (see page 34) and develop better ways to measure our performance in this area.

Monitoring our workforce profile

London and South East England

	Benchmark	Our staff (in post) 31 March 2012	31 March 2011
Black and Minority Ethnic	19%	18%	19%
Disabled	9%	8%*	7%*

Manchester and North West England

	Benchmark	Our staff (in post) 31 March 2012	31 March 2011
Black and Minority Ethnic	6%	6%	5%
Disabled	10%	4%*	3%*

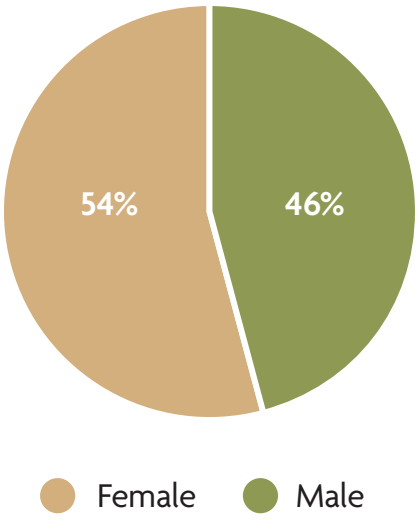
* These figures reflect staff self-identifying as disabled.

Our customers

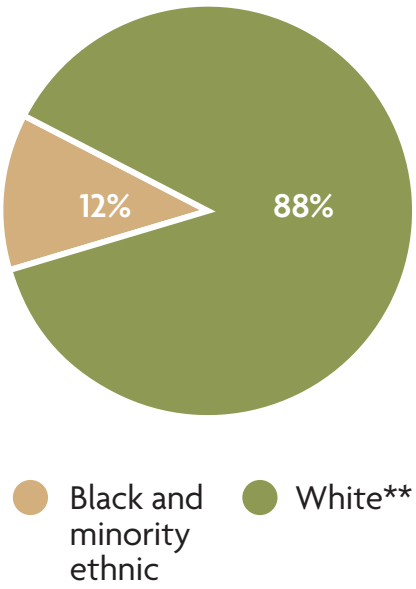
We are committed to understanding the different needs of our customers. Our rolling customer survey provides us with regular demographic information and feedback to help us provide a service that everyone can access.

In 2011-12 our survey told us the following about the people who contact us*:

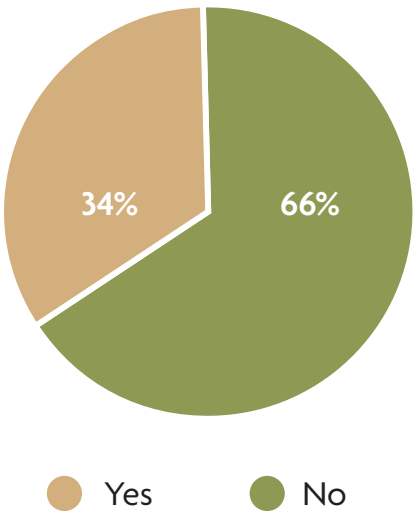
Gender



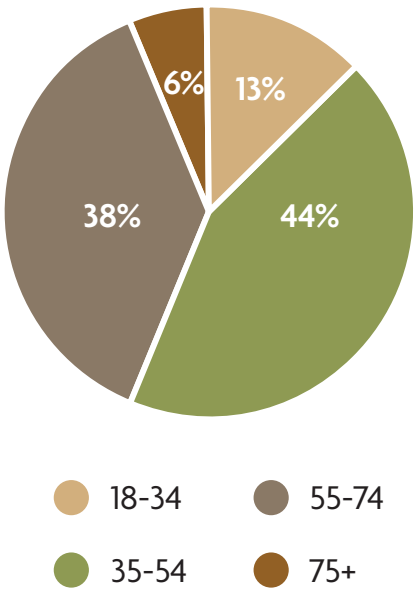
Ethnicity



Disability



Age



* All figures are taken from a random sample of our enquirers.
** White includes white minority ethnic groups.
Some percentages do not add up to 100 per cent due to rounding.

Our information promise

We want to share the learning from complaints and tell our customers and stakeholders more about us, our work and our decisions. Equally, we want to reassure those who send us personal, sensitive and sometimes confidential information that we will safeguard it and will handle it lawfully and appropriately. To meet this challenge, we developed and tested our information promise; a clear statement that we value all the information entrusted to us, will put appropriate resources in place to look after it and will report on how we are doing.

The essence of being human

In August six of our staff visited the offices of the Public Protector in South Africa. The purpose of the visit was to learn about our South African colleagues' approach to equality and diversity, their communications with hard-to-reach customer groups and their value of *'ubuntu'*. Ubuntu places a high premium on dignity, compassion, and respect for the humanity of another.

Our governance

The post of Parliamentary and Health Service Ombudsman is made up of two statutory roles – the Parliamentary Commissioner for Administration and the Health Service Commissioner for England. The Ombudsman is independent of government and has statutory responsibilities and powers to report to Parliament. She is solely responsible and accountable for the conduct and administration of all work carried out by her Office and for the decisions made. In January 2012 Ann Abraham retired as Ombudsman and Dame Julie Mellor, DBE took up the post.

To improve the transparency with which we operate, and to bolster the independence of the role, Ann Abraham established a non-statutory Advisory Board. The Advisory Board acts as a critical friend, supporting and advising the Ombudsman. External members are chosen because of their ability to bring a broad perspective to assist in the development of policy and practice.

As of 31 March 2012, the members of the Board were Paula Carter (Board Secretary at Channel 4), Linda Charlton (who has worked in the education sector, government departments and the National Health Service) and Tony Wright (former Chair of the Public Administration Select Committee).

Our governance arrangements also include:

- an Audit Committee, chaired by Sir Jon Shortridge (an experienced public servant and leader and former Permanent Secretary in Wales), responsible for providing advice and assurance to the Ombudsman as Accounting Officer, and to the Advisory Board and the Executive Board, on the adequacy and effectiveness of internal control and risk management; and
- a Pay Committee, responsible for providing advice on pay arrangements for the Office.

The Executive Board

An Executive Board, chaired by the Ombudsman and comprising the Deputy Ombudsman, the Deputy Chief Executive and the Director of Communications, manages the Office's functions and activities. The Executive Board is responsible for the delivery of the Office's strategic vision, policies and services to the public and other stakeholders.

Executive Board (as at 31 March 2012)

Dame Julie Mellor, DBE (Chair)
Ombudsman

Claire Forbes
Director of Communications

Kathryn Hudson
Deputy Ombudsman

Bill Richardson
Deputy Chief Executive

Advisory Board (as at 31 March 2012)
(external members)

Paula Carter

Linda Charlton

Tony Wright

Audit Committee

Sir Jon Shortridge (Chair)

Audit Committee (as at 31 March 2012)
(external members)

Sir Jon Shortridge (Chair)

Mei Sim Lai

Brian Landers

Pay Committee (as at 31 March 2012)
(external members)

Paula Carter

Linda Charlton

More information about our governance arrangements and the members of our Boards and Committees is available on our website at www.ombudsman.org.uk.

The challenges ahead

Our work to resolve complaints involves us in matters as wide ranging as farming and dentistry, immigration and defence. As we plan for the future, we are taking account of changes to public services and of wider discussions about the role of ombudsmen.

NHS reform

The *Health and Social Care Act 2012* will change the way healthcare in England is delivered. The abolition of strategic health authorities and primary care trusts and the introduction of the NHS Commissioning Board and clinical commissioning groups creates a new structure for the NHS. We are working with the Department of Health, regulators and others, such as patients' organisations, to ensure that the new structure delivers for patients and the public.

It is vital that high-quality complaint handling is embedded in the new NHS structure. Complaints offer an opportunity for patients' voices to be heard and these need to be listened to at a senior level. Clinical commissioning groups should set out clearly their expectations of high quality complaint handling from healthcare providers, and we will use our expertise and share our learning to help them support the delivery of this.

We will also continue our work with others to drive improvement and learning from NHS complaints information. The Mid-Staffordshire NHS Foundation Trust Inquiry has highlighted the importance of identifying and capturing trends and themes at an early stage. We are committed to playing our part in the development of more meaningful and comparable complaints information that can be used to strengthen the quality of services for patients and the public.

From July 2012 amendments to our legislation will enable us to share our decisions about NHS complaints more widely. When we decide not to investigate formally, we will be able to share the reasons for that with the organisation complained about. At the same time, we will publish more information about the NHS complaints coming to us, to highlight good practice as well as bad.

Public sector reform

The Government's *Open Public Services* White Paper aims to promote choice and competition in public services. It proposes opening public service provision to private and third sector providers. In our response to the White Paper, made jointly with the other public service ombudsmen in England and Wales, we welcomed the Government's recognition that ombudsmen have much to offer in ensuring fair access to public services for everyone.

The *Open Public Services* agenda highlights the need to explore the role of ombudsmen so that we can meet the challenges posed by a changing public sector. As that discussion continues, we want to ensure that there is a broader understanding of the key role we play in delivering administrative justice. We will continue to develop our relationship with Government and Parliament, including the Public Administration Select Committee, other Select Committees and the House of Lords, to drive that debate.

More impact for more people

We want our work to have more impact for more people. Moving forward, our priorities will be:

- continuing to improve the way we handle complaints from individuals;
- doing more to use the learning from our casework and our expertise to help improve public services for everyone;
- raising the public's, media's and Parliament's awareness of our role and work, so that more people understand how our service could help them; and
- using our expertise and experience to influence Parliament and government to make it easier for people to make complaints.

We have begun a project to refresh our corporate strategy to help us fulfil these priorities. As we have shown in this report, our performance over the last year is a strong platform that we can build on. But there is still more for us to do.

Earlier this year, we began talking to our customers, our staff, public services, the general public and parliamentarians about how we can increase our impact. These discussions are helping to shape our plans for the future. The ideas so far include:

- broadening and strengthening our relationship with Parliament;
- helping to make it easier and more straightforward for people to complain about public services;
- looking at new ways to gather information and data about complaints from people across society; and
- changing the law so that it is easier for people to come to us directly and so that we can examine potential systemic problems in public services.

We expect to publish our new strategy in autumn this year.

'... the time has finally come to acknowledge the power of own initiative investigation, to accept that, in the absence of a specific individual complaint, the Ombudsman should not stand idly by. The ability from time to time ... to seize the initiative, to catch the whiff of a scandal and run with it, is now a necessity not a luxury, especially if social justice is to reach some of the most vulnerable and marginalised people in society.'

Ann Abraham,
Annual Tom Sargent lecture,
13 October 2011

'What about all the people who can't navigate the system to come to us; those who are vulnerable, those who are in care, those who have some kind of cognitive impairment; older people who are distraught and therefore cognitive impaired?'

Dame Julie Mellor, DBE,
Financial Times,
16 April 2012

Our finances

The Parliamentary and Health Service Ombudsman's full Resource Accounts 2011-12 will be laid before Parliament on 10 July 2012 and will be available on our website at www.ombudsman.org.uk or from the Stationery Office.

Summary Financial Statements for the year ended 31 March 2012

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 2011-12, which were signed by the Ombudsman on 21 June 2012. While the summary below does not contain sufficient detail to allow a full understanding of the financial affairs of PHSO, it is 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 PHSO's 2011-12 Resource Accounts.

Dame Julie Mellor, DBE
Parliamentary and Health Service Ombudsman
21 June 2012

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

I have examined the Summary Financial Statements of the Parliamentary and Health Service Ombudsman for the year ended 31 March 2012, comprising a Summary of Resource Outturn, a Statement of Comprehensive Net Expenditure, a Statement of Financial Position, a Statement of Cash Flows and a Statement of Changes in Taxpayers' Equity.

Respective responsibilities of the Ombudsman and the auditor

The Ombudsman is responsible for preparing the Summary Financial Statements in accordance with the Government Financial Reporting Manual (FReM).

My responsibility is to report to you my opinion on the consistency of the Summary Financial Statements within the Ombudsman's Annual Report with the full annual financial statements and the Annual Report to the Resource Accounts, and its compliance with the relevant requirements of the FReM.

I also read the other information contained in the Ombudsman's Annual Report and consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the Summary Financial Statements.

I conducted my work in accordance with Bulletin 2008/3 issued by the Auditing Practices Board. My report on the Parliamentary and Health Service Ombudsman's full annual financial statements describes the basis of my opinion on those financial statements and on the Annual Report to the Resource Accounts.

Opinion

In my opinion, the Summary Financial Statements are consistent with the full annual financial statements for the Parliamentary and Health Service Ombudsman for the year ended 31 March 2012 and comply with the applicable requirements of the FReM.

Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London

25 June 2012

PHSO's 2011-12 funding arises from a four-year settlement sanctioned by HM Treasury, with annual Estimates based on this settlement approved by Parliament. Our four-year settlement for the period 2011-15 was sanctioned in October 2010. In April 2011, PHSO's Executive Board agreed a Financial Strategy for the four years 2011-12 to 2014-15. It provides the framework that will support and enable the delivery of the four-year settlement, including all necessary cash savings, whilst ensuring that PHSO can also deliver our strategic and enabling objectives effectively and efficiently. An underpinning four-year Capital Investment Strategy was also agreed.

PHSO's sanctioned 2011-12 baseline funding was amended in-year through a Supplementary Estimate, sanctioned in January 2012.

We met all six of our voted funding and budget limits and all seven of the financial management targets in our Corporate Business Plan.

The performance on each was as follows:

- our net resource underspend of £354k was within our target limit for underspending of less than £500k (£1,297k underspend in 2010-11); the underspend mainly comprises unused unallocated funding of £185k held in reserve; reduced spend for bought-in professional services of £104k; and expenditure offset by £64k of additional income mainly arising from the provision of more clinical advice services to other ombudsmen than was expected;
- our total capital underspend of £39k met our target limit for underspending of less than £100k (£503k underspend in 2010-11);
- we recovered 100% of retainable income due in the year, meeting our target of 100%;
- we remained within the Net Cash Requirement sanctioned by Parliament;
- we paid 99.7% (99.7% in 2010-11) of supplier invoices within our target of 99% of correctly presented invoices paid within 30 days of receipt;
- our resource budgets were managed to within 1% of agreed allocations, within our target of limiting budget variances to no more than 2%; and
- our month-on-month budget forecast variances were managed to an average accuracy of 1% over the year, within our tolerance target of no more than 2%.

Our sanctioned 2011-12 baseline resource and capital budgets for the year were as follows:

	Main Estimate £000	**Supp. Estimate** £000	**Revised Baseline** £000
Total Net Budget:			
Resource (Voted)	33,413	(200)	**33,213**
Resource (Non-Voted)	*187*	-	*187*
Capital	700	(50)	**650**

Statement of Parliamentary Supply
Summary of Resource Outturn 2011-12

	Estimate			Outturn				
	Voted £000	Non-Voted £000	Total £000	Voted £000	Non-Voted £000	Total £000	Voted outturn compared to Estimate: saving/ (excess) £000	Outturn £000
Departmental Expenditure Limit								
- Resource	**33,363**	-	33,363	**33,009**	-	33,009	**354**	33,084
- Capital	650	-	650	611	-	611	39	847
Annually Managed Expenditure								
- Resource	(150)	-	(150)	(158)	-	(158)	8	(239)
- Capital	-	-	-	-	-	-	-	-
Total Budget	**33,863**	**-**	**33,863**	**33,462**	**-**	**33,462**	**401**	**33,692**
Non-Budget								
- Resource	-	187	187	-	188	188	-	193
Total	**33,863**	**187**	**34,050**	**33,462**	**184**	**33,650**	**401**	**33,885**
Total Voted Resources	**33,213**	-	**33,213**	**32,851**	-	**32,849**	**362**	**32,845**
Total Capital	**650**	**-**	**650**	**611**	**-**	**611**	**39**	**847**
Total	**33,863**	**-**	**33,863**	**33,462**	**-**	**33,462**	**401**	**33,692**

Explanations for variances between Estimate and Outturn are given in note 2.1 and the Management Commentary.

For Estimates purposes, all PHSO's spend is classified as Programme. The Statement of Parliamentary Supply does not therefore report against an Administration Cost Limit.

Figures in the areas outlined in bold are voted totals subject to Parliamentary control.

Net Cash Requirement 2011-12

	2011-12			2010-11
	Estimate £000	Outturn £000	Net total outturn compared to Estimate: saving/ (excess) £000	Outturn £000
Net Cash Requirement	32,613	31,861	752	32,185

Statement of Comprehensive Net Expenditure for the year ended 31 March 2012

	2011-12	2010-11
	£000	£000
Administration costs		
Staff costs	21,619	21,325
Other administration costs	11,821	12,016
Gross administration costs	**33,440**	**33,341**
Operating income	(248)	(310)
Net administration costs	**33,192**	**33,031**
Net operating cost	**33,192**	**33,031**

Other comprehensive expenditure

Net gain/(loss) on revaluation of property, plant and equipment	5	11
Other comprehensive expenditure	**5**	**11**
Total comprehensive expenditure for the year ended 31 March 2012	**33,197**	**33,042**

All operations are continuing.

Statement of Financial Position as at 31 March 2012

	31 March 2012		31 March 2011	
	£000		£000	
Non-current assets				
Property, plant and equipment	4,348		5,308	
Intangible assets	285		279	
Total non-current assets		**4,633**		**5,587**
Current assets				
Trade and other receivables	1,375		1,427	
Cash and cash equivalents	68		45	
Total current assets		**1,443**		**1,472**
Total assets		**6,076**		**7,059**
Current liabilities				
Trade and other payables	(2,338)		(2,023)	
Other liabilities	(136)		(111)	
Total current liabilities		**(2,474)**		**(2,134)**
Non-current assets less net current liabilities		**3,602**		**4,925**
Non-current liabilities				
Provisions	(521)		(679)	
Other liabilities	(405)		(476)	
Total non-current liabilities		**(926)**		**(1,155)**
Assets less liabilities		**2,676**		**3,770**
Taxpayers' equity				
General Fund		2,201		3,243
Revaluation Reserve		475		527
Total taxpayers' equity		**2,676**		**3,770**

Dame Julie Mellor, DBE
Parliamentary and Health Service Ombudsman
21 June 2012

Statement of Cash Flows for the year ended 31 March 2012

	2011-12	2010-11
	£000	£000
Cash flows from operating activities		
Net operating cost	(33,192)	(33,031)
Adjustments for non-cash transactions	1,636	1,566
(Increase)/decrease in trade and other receivables	52	10
Increase/(decrease) in trade payables	269	37
"Less movements in payables/receivables relating to items not passing through the Statement of Comprehensive Net Expenditure"	(26)	(10)
Use of provisions	(160)	(239)
Net cash outflow from operating activities	**(31,421)**	**(31,667)**
Cash flows from investing activities		
Purchase of property, plant and equipment	(471)	(548)
Purchase of intangible assets	(154)	(158)
Net cash outflow from investing activities	**(625)**	**(706)**
Cash flows from financing activities		
From the Consolidated Fund (Supply): current year	31,886	32,204
From the Consolidated Fund (Non-Supply)	188	193
Net financing	**32,074**	**32,397**
Net increase/(decrease) in cash and cash equivalents in the period before adjustment for receipts and payments to the Consolidated Fund	**28**	**24**
Payments of amounts due to the Consolidated Fund	(5)	(16)
Net increase/(decrease) in cash and cash equivalents in the period after adjustment for receipts and payments to the Consolidated Fund	**23**	**8**
Cash and cash equivalents at the beginning of the period	**45**	**37**
Cash and cash equivalents at the end of the period	**68**	**45**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2012

	General Fund	Revaluation Reserve	Total Reserves
	£000	£000	£000
Balance at 31 March 2010	**3,783**	**590**	**4,373**
Net Parliamentary Funding - drawn down	32,204	-	32,204
Net Parliamentary Funding - deemed	21	-	21
Consolidated Fund Standing Services	193	-	193
Supply payable adjustment	(40)	-	(40)
CFERs payable to the Consolidated Fund	(7)	-	(7)
Comprehensive net expenditure for the year	(33,031)	-	(33,031)
Non-cash charges - auditor's remuneration	50	-	50
Net gain/(loss) on revaluation of property, plant and equipment	(4)	11	7
Transfers between reserves	74	(74)	-
Balance at 31 March 2011	**3,243**	**527**	**3,770**
Net Parliamentary Funding - drawn down	31,886	-	31,886
Net Parliamentary Funding - deemed	40	-	40
Consolidated Fund Standing Services	188	-	188
Supply payable adjustment	(65)	-	(65)
CFERs payable to the Consolidated Fund	(6)	-	(6)
Comprehensive net expenditure for the year	(33,192)	-	(33,192)
Non-cash charges - auditor's remuneration	50	-	50
Net gain on revaluation of property, plant and equipment	5	-	5
Transfers between reserves	52	(52)	-
Balance at 31 March 2012	**2,201**	**475**	**2,676**

The General Fund serves as the operating fund. The General Fund is used to account for all financial resources except those required to be accounted for in another fund.

The Revaluation Reserve records the unrealised gain or loss on revaluation of assets.

Appendix

Statistical information about enquiries received, complaints accepted for formal investigation and investigations reported on during 2011-12.

Figure 1. Enquiries received, closed and in hand

	Restated in hand (01/04/11)	Received	Closed	Total in hand at (01/04/12)
Total	1,400	23,846	23,889	1,357

Figure 2. Types of closed enquiries

	Out of remit	Not properly made[1]	Premature[2]	Discretion[3]	Withdrawn	Accepted for formal investigation	Total
Total	3,298	9,018	5,440	4,311	1,401	421	23,889
%	14%	38%	23%	18%	6%	2%	

The percentages do not add up to 100 per cent due to rounding.

1 Not properly made: the complainant has not completed local resolution with the body concerned before bringing the matter to us and/or has not submitted their complaint in writing (NHS), or has not obtained an MP referral (complaints about government agencies and departments).

2 Premature: the complainant has not attempted to resolve the complaint with the body concerned first, or has not completed the local resolution process.

3 Discretion: we may decide not to accept a complaint for formal investigation for a variety of reasons, for example, we may feel that the body has acted correctly, reasonably, or, where there have been errors, that the complainant has already been offered appropriate redress. This includes enquiries where we achieved a remedy without the need for an investigation.

Figure 3. Enquiries accepted for formal investigation, investigations concluded and in hand

	Restated in hand (01/04/11)	Accepted for formal investigation	Reported on	Discontinued	In hand (31/03/12)
NHS	247	328	309	7	259
Government departments and agencies	74	93	94	0	73
Total	321	421	403	7	332

Parliamentary and Health Service Ombudsman

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