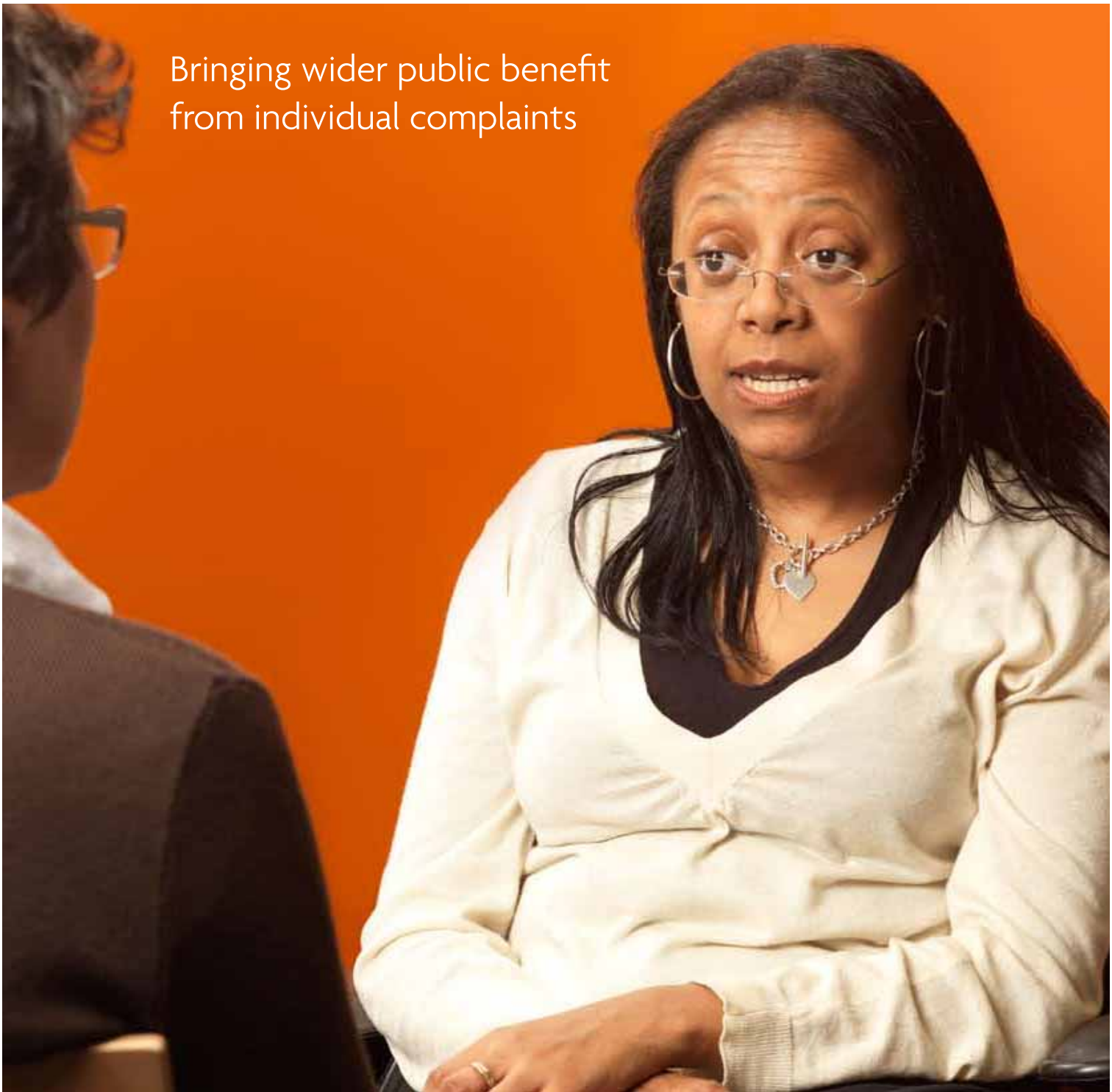
Parliamentary and Health Service Ombudsman

Annual Report 2007-08



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 aim and 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 shape our behaviour, both as an organisation and as individuals working in PHSO, and incorporate our *Principles of Good Administration*.

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 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.

Parliamentary and Health Service Ombudsman

Annual Report 2007-08

5th Report – Session 2007-08

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

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Foreword

Maintaining an independent voice at the heart of our democracy

The work of my Office during the course of 2007-08 reflects its place in the constitution and its twin functions of delivering individual benefit to complainants and serving the wider public benefit. It achieves this larger ambition by drawing on its experience, expertise and independence to right individual wrongs and drive improvements in public services. It is this fruitful mix of individual benefit and public benefit that gives the Office its distinctive character.

In July 2007 the Government started consultation on its proposals for constitutional reform with the publication of a Green Paper, *The Governance of Britain*. That process has provided an opportunity for me to reaffirm the place of the Ombudsman in our constitutional arrangements. When the Wilson Government established the Office in 1967, part of its purpose was to support Parliament in holding to account the Executive, the government of the day. The way it was to do that was by assisting MPs with the task of investigating complaints made to them by citizens about their dealings with central government departments. This was not just an alternative to the civil justice system. It was to be a way of ensuring that Parliament could guarantee an independent and authoritative voice for aggrieved citizens.

The Court of Appeal's judgment in February 2008 in the long-running litigation arising from my 2006 report, *Trusting in the Pensions Promise*, has also provided welcome reinforcement of the Ombudsman's constitutional position. That judgment has confirmed that, although the Ombudsman's findings are not binding on Government, the relevant Minister must either accept them or alternatively establish good reason for not doing so. In effect, the judgment requires the Minister to have 'due regard' to the Ombudsman's findings. I consider that a satisfactory outcome and a helpful contribution to a viable framework for future relations between my Office and Government. It is a judgment that sits well with what I see as one of the Ombudsman's key roles: playing an active part in the deliberative parliamentary process.

That key role has been evident in the past year in connection with tax credits. In October 2007 I published a second special report, *Tax Credits: Getting it wrong?*, to provide an update on the recommendations made in my first report and to give an indication of progress towards correcting the problems I had

previously identified. I am pleased to say that HM Revenue & Customs accepted all the recommendations in my second report and is taking action to implement them. This is, in my view, a good example of the deliberative process in action, with my Office playing its proper part by eliciting a reasoned response and effective remedial action from government.

As part of my function of delivering broader public benefit, I have during the course of 2007-08 published new guidance in the form of *Principles for Remedy*, to complement *Principles of Good Administration* published last year. I have recently finished consulting on a third publication, *Principles of Good Complaint Handling*, which we will publish in autumn 2008. These various Principles draw on the experience and expertise of my Office to propose an objective framework within which public authorities should seek to work. At the same time, the Principles help clarify the expectations against which I will judge performance. In short, the principles of legality, flexibility, transparency, fairness and accountability are what I regard as the necessary ingredients of good administration; and if good administration is in part an attempt to humanise the workings of bureaucracy, remedial action is the attempt to restore that sense of human value to those who have been denied it. *Principles of Good Administration* and *Principles for Remedy* are different sides of the same coin.

None of this work is conducted in isolation from Ombudsmen colleagues at home and abroad, and this collaborative work is something to which I draw further attention later in this Report. At home, the past year has seen the implementation of a new Regulatory Reform Order that for the first time formalises joint investigations by my Office and the Local Government Ombudsman. It has already been put to effective use in dealing with a complaint that crossed the boundary between local authority and central government social and healthcare responsibilities. Further afield, the Council of Europe's Human Rights Commissioner, Thomas Hammarberg, has encouraged Ombudsmen throughout Europe to co-operate more effectively with his Office and with national human rights institutions to help uphold human rights principles in public administration. I was very pleased to welcome Mr Hammarberg to my Office during his recent visit to the UK and look forward to contributing to the initiative that he has prompted in the year ahead, not least by liaising, when appropriate, with the new Equality and Human Rights Commission and with the Parliamentary Joint Committee on Human Rights.

The key organisational challenges will, however, occur much closer to home. In April 2009, a new system for handling complaints in the NHS will come into force, with increased emphasis on the need for local resolution and with the Ombudsman acting as the second stage in the complaints process, after NHS bodies and individuals themselves have concluded their involvement. This development, despite its short-term organisational challenges, holds out the prospect of longer-term improvements to the system and is one that I warmly welcome. For my own Office it represents yet a further opportunity to deliver individual benefit to those already aggrieved and wider public benefit to all those countless citizens who will make use of the NHS in the future. It is therefore just one aspect of that larger project of delivering meaningful individual and public benefit, upon which it continues to be my privilege to be fruitfully engaged.

Ann Abraham
Parliamentary and Health Service Ombudsman

October 2008

Government departments, agencies and public bodies

In 2007-08 we received 6,964 enquiries relating to 7,341 complaints against government departments, agencies and public bodies. The bodies and their agencies most complained about were: the Department for Work and Pensions; Her Majesty's Revenue & Customs; what is now the Ministry of Justice; and the Home Office

We accepted 248 cases for investigation and reported on 290 investigations. 68% of complaints were upheld in full or in part.

Enquiries

Figure 1 shows the top five government departments and agencies complained about. The Department for Work and Pensions (DWP) and its agencies, taken together, topped the list, accounting for over a third of all the complaints made to the Parliamentary Ombudsman. They were followed close behind by Her Majesty's Revenue & Customs (HMRC), primarily but not exclusively as a result of continuing problems with tax credits. We noted an increasing number of complaints about the Border and Immigration Agency, formerly the Immigration and Nationality Directorate of the Home Office and, from 1 April 2008, the UK Border Agency; and about the Department for Transport and its agencies. However, the number of complaints about the Ministry of Justice, in its various incarnations, fell.

Figure 1
Top 5 departments by number of complaints received

Department for Work and Pensions	**Received**
Jobcentre Plus	1,063
Child Support Agency	868
The Pension Service	224
Independent Case Examiner	147
Disability and Carers Service	114
Department for Work and Pensions	52
Debt Management Unit	43
Health and Safety Executive	25
Pensions Ombudsman	19
Rent Service	6
Health and Safety Commission	5
Disability Rights Commission	4
Independent Living Funds	3
Remploy Ltd	1
Total	**2,574**

Figure 1 *continued*
Top 5 departments by number of complaints received

HM Revenue & Customs (HMRC)	Received
HM Revenue & Customs	1,791
The Adjudicator's Office*	512
National Insurance Contributions Office	37
Child Benefit Office	2
Total	**2,342**

Ministry of Justice	Received
HM Courts Service	152
Legal Services Commission	102
Tribunals Service	100
HM Prison Service	53
Information Commissioner	39
Land Registry	34
Ministry of Justice**	25
The Office of the Public Guardian	18
Prisons and Probation Ombudsman	9
Office of Social Security and Child Support Commissioners	4
Official Solicitor	4
Legal Complaints Service	3
The National Archives	2
Advisory Council on National Records and Archives	1
Court Funds Office	1
Immigration Appellate Authority	1
Judicial Appointments and Conduct Ombudsman	1
Total	**549**

*not all complaints about HMRC
**includes 9 against Department for Constitutional Affairs

Home Office	Received
Border and Immigration Agency	277
Criminal Records Bureau	40
Home Office	40
UKvisas***	39
Identity and Passport Service	35
Criminal Injuries Compensation Authority	32
Security Industry Authority	27
Criminal Injuries Compensation Appeals Panel	8
Office of the Immigration Services Commissioner	3
Parole Board	2
Central Police Training and Development Authority	1
Correctional Services Accreditation Panel	1
Forensic Science Service	1
National Policing Improvement Agency	1
Total	**507**

Department for Transport	Received
Driver and Vehicle Licensing Agency	194
Driving Standards Agency	23
Highways Agency	20
Department for Transport	17
Vehicle and Operator Service Agency	17
Maritime and Coastguard Agency	6
Total	**277**

***UKvisas was joint Home Office and Foreign & Commonwealth Office, now Home Office only

Interventions

There is a growing category of complaints where we seek to achieve resolution without recourse to full investigation. We call these 'interventions' and we closed a number of cases in this way during 2007-08. In case study 1 the Rent Service of DWP made a mistake calculating Mr N's housing benefit. The error was corrected as a result of our enquiries.

Investigations

Formal investigations involve detailed and thorough examination of the facts of a case. They often run to months, or occasionally years, of work. They are also in a minority, because most complaints referred to us are not considered appropriate for full investigation.

We accepted 248 cases for investigation relating to 331 complaints.

Figure 2 shows the top five government departments and agencies in respect of which we accepted complaints for investigation. Again, HMRC, DWP, the Home Office and the Ministry of Justice topped the list.

We reported on a total of 290 investigations in 2007-08, covering 346 complaints. We upheld 37% of complaints in full and partly upheld a further 31%. Figure 3 shows the top five departments and agencies in respect of which we reported on investigations, and their outcomes.

Figure 19 in Chapter 4 of this report gives full details of all our investigations of complaints about government departments, agencies and public bodies and their outcomes.

1
Case Study

Mistake over narrowboat led to housing benefit cut

Mr N applied for housing benefit in April 2003 to cover the rent for his narrowboat. The rent was determined by the Rent Service at the time to be £35.99 per week. In April 2006 Mr N's weekly rent was increased to £41.65 and his housing benefit was increased accordingly. However, in June 2006 the Rent Service determined the rental value of Mr N's narrowboat to be £29.92, as a result of which he was required to pay £11.73 per week in rental charges from his own finances. Mr N complained to the Ombudsman that the Rent Service had decreased the rental value of his narrowboat even though the rent had risen, causing a shortfall in his housing benefit.

In response to our enquiries, the Rent Service revisited Mr N's case and discovered that an error had been made in categorising the narrowboat. It explained that the narrowboat had been banded by the local authority as being between 10 and 15 metres long when it was in fact 16 metres long and should therefore have been placed in a higher band. That had led to a reduction in the rental value which in turn had decreased Mr N's housing benefit entitlement. The Rent Service told us it had determined the rental value of Mr N's narrowboat to be £40.81 per week, and that the local authority had agreed to backdate his housing benefit and pay arrears.

Figure 2
Top 5 departments by number of complaints accepted for investigation

HM Revenue & Customs	Accepted for investigation
HM Revenue & Customs	91
The Adjudicator's Office*	68
National Insurance Contributions Office	1
Total	**160**

Home Office	Accepted for investigation
Border and Immigration Agency	46
Criminal Injuries Compensation Authority	1
UKvisas**	1
Total	**48**

Department for Work and Pensions	Accepted for investigation
Jobcentre Plus	38
Child Support Agency	18
Independent Case Examiner	9
Debt Management Unit	5
The Pension Service	4
Disability and Carers Service	3
The Pensions Regulator	1
Total	**78**

Ministry of Justice	Accepted for investigation
HM Courts Service	7
Legal Services Commission	6
HM Prison Service	5
Ministry of Justice	1
National Probation Service	1
Official Solicitor	1
Tribunals Service	1
Total	**22**

Department for Environment, Food and Rural Affairs	Accepted for investigation
Department for Environment, Food and Rural Affairs	4
Rural Payments Agency	2
Consumer Council for Water	1
Environment Agency	1
Total	**8**

*not all complaints about HMRC
**UKvisas was joint Home Office and Foreign & Commonwealth Office, now Home Office only

Figure 3
Top 5 departments by number of complaints reported on

Department for Work and Pensions	**Reported on**	**Fully upheld**	**Partly upheld**	**Not upheld**
Jobcentre Plus	52	29%	38%	33%
Child Support Agency	28	54%	36%	11%
The Pension Service	13	31%	38%	31%
Debt Management Unit	8	13%	75%	13%
Independent Case Examiner	7	14%	0%	86%
Disability and Carers Service	6	33%	33%	33%
Department for Work and Pensions	2	50%	0%	50%
Health and Safety Executive	2	50%	50%	0%
Total	**118**	**34%**	**37%**	**29%**

HM Revenue & Customs	**Reported on**	**Fully upheld**	**Partly upheld**	**Not upheld**
HM Revenue & Customs	66	41%	27%	32%
The Adjudicator's Office*	26	15%	8%	77%
National Insurance Contributions Office	1	0%	0%	100%
Total	**93**	**33%**	**22%**	**45%**

Home Office	**Reported on**	**Fully upheld**	**Partly upheld**	**Not upheld**
Border and Immigration Agency	52	52%	33%	15%
Criminal Records Bureau	6	17%	67%	17%
UKvisas**	3	67%	0%	33%
Security Industry Authority	2	50%	50%	0%
Criminal Injuries Compensation Appeals Panel	1	0%	100%	0%
Criminal Injuries Compensation Authority	1	0%	100%	0%
Home Office	1	0%	100%	0%
Identity and Passport Service	1	0%	0%	100%
Total	**67**	**46%**	**37%**	**16%**

*not all complaints about HMRC
**UKvisas was joint Home Office and Foreign & Commonwealth Office, now Home Office only

Ministry of Justice	**Reported on**	**Fully upheld**	**Partly upheld**	**Not upheld**
HM Courts Service	17	47%	18%	35%
HM Prison Service	3	0%	67%	33%
Legal Services Commission	3	33%	33%	33%
Information Commissioner	1	0%	100%	0%
Land Registry	1	0%	0%	100%
Ministry of Justice	1	0%	100%	0%
Tribunals Service	1	0%	0%	100%
Total	**27**	**33%**	**30%**	**37%**

Department for Environment, Food and Rural Affairs	**Reported on**	**Fully upheld**	**Partly upheld**	**Not upheld**
Department for Environment, Food and Rural Affairs	6	17%	33%	50%
Rural Payments Agency	3	67%	33%	0%
Environment Agency	2	0%	0%	100%
Consumer Council for Water	1	0%	0%	100%
Total	**12**	**25%**	**25%**	**50%**

Individual and public benefit

Our Parliamentary work during 2007-08 clearly illustrated the dual aspect of the Ombudsman's role in achieving remedy in individual cases, while also providing wider public benefit. This wider benefit stems from the effective use of our evidence base and our expertise in providing a high quality complaint handling service, together with an acknowledged reputation for independence and impartiality. This enables us to provide expertise in good administration and good complaint handling, drive improvements in public service delivery and inform public policy, demonstrating that the Ombudsman not only provides a retrospective remedy for injustice resulting from maladministration, but also seeks to secure prospective improvements in the wider public interest.

This approach was evident in the work we undertook in relation to the three bodies that attracted the most complaints in the year:

- In relation to **Her Majesty's Revenue & Customs**, including the Adjudicator's Office, we reported on 54 tax credit investigations in the year and also published our second special report on the subject, *Tax Credits: Getting it wrong?,* making recommendations for systemic change, all of which were accepted.

- In relation to the **Department for Work and Pensions** and its agencies we reported on 98 cases relating to 118 complaints. We also welcomed the extension of the remit of DWP's Independent Case Examiner to include all of DWP's customer-facing agencies, something the Ombudsman had recommended as far back as 2003.

- In relation to the **Border and Immigration Agency** we reported on 52 investigations in the year and, in a series of liaison meetings with the Chief Executive of the Agency, made strong representations about the need for a more robust and effective system for handling complaints.

More detail is given later about the work we undertook with these three major bodies during the year.

A Framework of Principles

After wide consultation, in October 2007 we published our *Principles for Remedy*, which offer complementary guidance to our *Principles of Good Administration*, published in March 2007. The *Principles for Remedy* follow the same six Principles as our *Principles of Good Administration*:

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

Principles for Remedy gives our view of the Principles that should guide public bodies in providing remedies for injustice resulting from their maladministration. We want public bodies to be fair and take responsibility, acknowledge failures and apologise for them, make amends and use the opportunity to improve their services.

During 2007-08 we developed the third in our series of Principles, which we have been consulting on in recent months and will publish in autumn 2008. Our *Principles of Good Complaint Handling* are based on the same six core Principles as our *Principles of Good Administration* and *Principles for Remedy*. With them we aim to ensure that public bodies understand how we expect complaints to be handled, and that complainants understand how we will consider their cases. As with the existing Principles, we hope that they will prove useful to both complaint handlers and complainants.

Poor complaint handling by public bodies was a recurrent theme across our Parliamentary investigations in 2007-08, and one we refer to frequently in the pages that follow. Often, the failure to provide an adequate remedy is an element of poor complaint handling, and is a significant factor in the complainant's decision to refer the complaint to us for investigation, as in the following example.

Poor complaint handling

Our investigation into the case of Mr W, a worker in the security industry, upheld his complaint that the Security Industry Authority had not properly handled his complaint about a lost application and had failed to explain its procedure to him adequately. As a result of our investigation, the Security Industry Authority not only agreed to put things right for Mr W, but also accepted our recommendation that it review its complaints process to prevent a recurrence of the problems Mr W had experienced.

2
Case Study

Complaints process was not fully explained

In July 2006 Mr W sent the Security Industry Authority (the Authority) an application form for a door supervisor's licence. The Authority wrote back to Mr W saying that his form was incomplete; it enclosed not his identification documents, but the application form of a third party, Mr A. Mr W told the Authority that it had sent him Mr A's application form and he asked where his own form was. The Authority said human error had probably led to Mr W's application being separated from his documents and replaced with Mr A's application. Mr W was invited to write in to complain.

After several attempts, in November the Authority finally managed to contact Mr A, who confirmed that he had received someone else's application form. He said he would return it to the Authority. Having not received the application form back, the Authority contacted Mr A again asking him to return it as soon as possible. Following a further exchange of correspondence with Mr W, in February 2007 the Authority refunded his £190 application fee as a goodwill gesture. Mr W acknowledged the gesture but said he could not accept that the Authority took all complaints seriously; that he had not been made aware of its complaints policy or procedure and had not been kept informed of progress. He said that the Authority had still not addressed all of his concerns.

We upheld Mr W's complaint in full. We found that the Authority had probably sent his application form containing personal details to a third party. It is the seriousness of this error, at a time when crime related to identity theft is much reported in the media, and in the knowledge that such crime can have a wide-ranging effect on victims, that led us to find the Authority's actions maladministrative. However, we saw nothing to suggest that the mistake was a result of systemic problems. The Authority did not answer Mr W's concerns about its complaints process and should have done more to explain it to him.

The Authority agreed to apologise to Mr W for not fully explaining its complaints process to him, and to review the complaints process, with particular attention to the need to make information about it publicly available.

In some cases, the errors that led to a complaint are compounded at the complaint handling stage by well-intentioned but ultimately counter-productive efforts to resolve problems informally. In an investigation involving the Department for Communities and Local Government we found that a 14-month delay resulted in this way when the Department attempted to negotiate a voluntary agreement to settle the matter, before eventually starting formal modification procedures.

3
Case Study

Planning mistake contributed to closure of store

Solicitors complained on behalf of their client, a major retailer, about an error in a letter issued by the Government Office for the East Midlands, now part of the Department for Communities and Local Government (the Department) – on behalf of the then Secretary of State – granting planning permission to a development company. They also complained that the failure to correct that error had caused the client unnecessary expenses and a loss of business at one of its stores.

We fully upheld the complaint. In granting planning permission to the developer, a restrictive condition on goods that could be sold was omitted, and a condition relating to the floor space available for food retailing was ambiguously worded, which arguably increased the amount of floor space allowed. That error was compounded by incorrect assurances of prompt action to rectify matters (as a result of which other parties, specifically the local council, failed to take action themselves which might have been successful). There was a failure to take account of all the relevant factors when deciding how to put things right. That led to the Department spending some 14 months trying to negotiate a voluntary agreement before starting formal modification procedures, and then deferring those procedures while the Secretary of State considered a planning application from another developer who had purchased the land to which the faulty planning permission related.

We found that the Department's error and its failure to correct it promptly was not the sole cause of the store's subsequent closure, but that it did lead to injustice. That was because the context of all future planning decisions for the land in question was irrevocably altered, and the erroneous permission granted became a significant factor in future planning decisions, eventually leading to the opening of a superstore directly opposite the client's store. That adversely affected the store's profits, and contributed to its closure.

In the light of all the contributing factors, we considered it reasonable for the Department to meet, in broad terms, 20% of a properly substantiated claim for losses from the store, together with any additional unnecessary costs that it had incurred in trying to have the Department's error corrected. The Department agreed to apologise to the retailer and to make a payment in line with our recommendations.

4
Case Study

Delay on asylum decision caused distress and hardship

Ms V, a Nigerian national, is thought to have arrived in the UK some time during 1988-89, to join her father, Mr V. In February 1993 the Immigration and Nationality Directorate of the Home Office (IND) told Mr V that he had no basis to stay in the UK and would have to leave immediately. IND had no further contact with Ms V or her father until February 1998, when solicitors requested further leave to remain, on the basis of Mr V's marriage to a French national.

Mr V was subsequently granted a European Economic Area (EEA) family residence permit until 10 February 2004. In February 2004 Mr V applied for indefinite leave to remain as the family member of an EEA national (with Ms V included as a dependant). In May Ms V applied for indefinite leave to remain based on her long residence, and shortly afterwards IND refused Mr V's application. They wrote to ask Ms V for further information in support of her application on 27 September 2006. In October IND was informed that Ms V was pregnant. In December Ms V applied for income support and other maternity-related benefits but was ineligible because she had no National Insurance number. In January 2007 Ms V told what was by now the Border and Immigration Agency she was homeless and pregnant. In March the Agency requested further information in support of Ms V's application.

Ms V complained to the Ombudsman about the Agency's delay in deciding her application, which she said had meant she could not obtain stable employment or claim state benefits. Her debts were growing. She was almost nine months pregnant with twins and concerned that her children would be removed if her application was not determined.

We upheld Ms V's complaint. Apart from its letter of 27 September 2006 (which Ms V did not receive because it was sent to the wrong address) the Agency took no meaningful action on her case between May 2004 and March 2007, and did not consider prioritising it on learning that she was pregnant and homeless. Although the Agency subsequently granted Ms V indefinite leave to remain on 17 May 2007, that did not completely remedy the injustice to her, as we considered that she would have obtained a National Insurance number and successfully claimed benefits, but for the Agency's maladministration. The Agency agreed to consider a claim from Ms V equivalent to income support forgone between 1 January and 17 May 2007 and equivalent to child benefit and child tax credit forgone between 20 March and 17 May 2007. In addition the Agency accepted that Ms V had been inconvenienced at a time when she could have been considered to be particularly vulnerable, and awarded her a consolatory payment of £300.

The need for local leadership

Public service providers should operate a complaint handling service that is fit for purpose and responsive, and their senior managers should understand the value of taking on board the lessons learnt from complaints. For these things to happen, it is necessary for managers at all levels to take a lead in ensuring that complaints are taken seriously and handled properly. However, this often does not happen.

Lack of local leadership in complaint handling by senior managers within departments and agencies was another clear thread running through our casework in 2007-08. In some cases it was a factor in a complainant's decision to refer a complaint to us, when timely local resolution might well have been possible if a senior manager had taken appropriate action at an earlier stage.

For instance, in the case of Ms V, a Nigerian national, the Border and Immigration Agency took no meaningful action on her asylum application for almost three years and did not consider prioritising it even after she told them she was pregnant and homeless. Leave was subsequently granted, but it is clear that local leadership was sadly lacking both in the initial handling of the case and in the Agency's reaction to Ms V's concerns about the long delay in processing her application.

Her Majesty's Revenue & Customs

Of the 91 complaints against HMRC accepted for investigation during 2007-08, 85% were about tax credits. Similarly, 91% of the 68 complaints accepted against the Adjudicator's Office were about their handling of tax credit complaints.

It is clear that, despite the considerable improvements HMRC has made in its administration of tax credits, it still has a long way to go to be appropriately customer-focused. It is also clear that many tax credit recipients still do not understand how the tax credit system works, and their complaints can often, therefore, relate to the system working as it is intended.

Most of the tax credit cases referred to us for investigation in 2007-08 related to the recovery of overpayments. Most stemmed from the early years of the scheme (2003-06), after which, in the 2006-07 tax year, HMRC changed the level of income disregarded from £2,500 to £25,000. A number of factors hampered our ability to process HMRC cases during the year. The most significant three are outlined below.

- **Section 18**
  About 25% of the tax credit cases we assessed or investigated in 2007-08 were affected by the 'section 18' procedural error announced in Parliament in July 2007. As a result of this error, HMRC is required to review approximately 250,000 tax credit cases, which it says may take up to three years to complete. This has already led to some delays in the resolution of cases because HMRC is unable to provide accurate information to the Ombudsman, the Adjudicator or its own complaints teams on an affected case, until the review of that case has been completed.

- **Code of Practice 26**
  Uncertainty over whether changes to the application of Code of Practice 26 (COP 26: the guidance HMRC use to determine whether to waive overpayments) would be applied retrospectively delayed most of our tax credit assessments and investigations for several weeks at the start of 2008 until the position was clarified by HMRC.

- **Lost CD-ROMs**
  Our ability to progress with some investigations was affected by the loss in November 2007 by HMRC of two CD-ROMs. These contained the personal details of families receiving child benefit. As a result of the loss, HMRC had to review the security of all its external communication channels and was accordingly unable to communicate with us by post, fax or email for a number of weeks, and unable to recommence sending us telephone recordings (relevant to many cases) for over three months.

Still getting things wrong

It is clear from the complaints received that attempts by HMRC to recover overpayments made under the tax credit system continue to cause distress and hardship for a significant number of people. As one complainant put it: *'Tax credits are supposed to help families, not cause them money worries'.*

In June 2005 the Ombudsman published *Tax Credits: Putting Things Right,* her first special report on the issue. This concluded that many of the difficulties families were facing were a result of HMRC having developed a 'one size fits all' system that was designed to require minimum human intervention, being mainly IT-based. The consequences of this systemic inflexibility are seen in the case of Mr C.

5
Case Study

Personal circumstances not properly considered when demanding tax credit repayment

Mr C undertook seasonal work from March to September 2005. In February 2006 the Citizens Advice Bureau sent HMRC a tax credit application form, together with a letter asking for the award to be backdated for the period of Mr C's employment. The letter explained that Mr C had been unable to look after his financial affairs for some time because of mental health problems and hospitalisation.

HMRC wrongly treated Mr C's application as a fresh claim going forward and awarded tax credits from 10 February 2006 onwards. An award notice was issued on 10 March, which also set out the award for 2006-07. In June Mr C's mother (Mrs M) told HMRC that it had paid tax credits to Mr C to which he was not entitled. HMRC terminated the award and sent Mr C a notice saying that he had been overpaid £578.88 for 2005-06 and £605.08 for 2006-07.

Mrs M complained to the Adjudicator, who found no grounds for asking HMRC to remit the overpayments: she said that it was clear from the March 2006 notice that the award was for the period from 10 February 2006 onwards, and it was not reasonable for Mr C to think he was entitled to the payments received. Mr C successfully appealed against HMRC's decision not to backdate his award for the period of his employment and received arrears of £964.81.

Mr C complained to the Ombudsman that recovery of the overpayment would deny him his correct benefit entitlement (his income support payments had stopped when he was awarded tax credits, and could not be reinstated retrospectively). He also complained that the Adjudicator had endorsed HMRC's decision not to remit the overpayment.

We upheld Mr C's complaint. HMRC knew in February 2006 that Mr C had no ongoing entitlement to tax credits, but it did not terminate the award until June. When considering whether to remit the overpayments, HMRC and the Adjudicator took insufficient account of Mr C's personal circumstances, which were such that he was in no position to check his award notice. HMRC agreed to remit the overpayments (accepting that the tax credit award had prevented Mr C from receiving his proper income support entitlement).

In October 2007 the Ombudsman published her second report, *Tax Credits: Getting it wrong?*, to provide an update on the implementation of recommendations made in the first report and give an indication of progress towards correcting the problems previously identified.

Tax Credits: Getting it wrong? made six recommendations. These included the production of a clear and comprehensive guide on the application of the revised COP 26, together with training for staff in its application and the desired outcomes. The report also recommended that HMRC develop feedback mechanisms to enable staff to learn from complaints about the unreasonable application of COP 26, and that HMRC ensure that proper consideration is given to the impact of recovery decisions on the individuals and families concerned.

The Government accepted all recommendations in the report and is taking action to implement them. A key improvement is the revision of COP 26 to better reflect the balance of responsibilities on both tax credit claimants and HMRC. HMRC must now take responsibility for acting promptly when told of a change in claimants' circumstances and for correcting errors notified to it, as in the case of Mrs K.

HMRC has shown a clear will to improve the experience of people claiming tax credits, especially among the most vulnerable groups. We hope this will lead to a significant reduction in cases being referred to the Ombudsman for investigation in the future.

6
Case Study

Wrong advice led to confusion about tax credit overpayment

Mrs K received tax credits as a single person from 6 April 2003. On 20 June she told HMRC that Mr K had been living with her since the start of the tax year. HMRC sent her an award notice in June showing that she was not entitled to tax credits for 2003-04 on her single claim. The notice incorrectly said Mrs K had no qualifying children. When she queried that, HMRC told her to ignore the notice. For the same reason, Mrs K ignored a notice received in July which again said she had no qualifying children (and which said she had been overpaid £1,673.57 on her single claim).

In August 2003 HMRC awarded Mr and Mrs K tax credits for 2003-04 on their joint claim. Mrs K's previous weekly payments had been higher and so she assumed that HMRC had taken any corrective action needed over her single award. The award notice did not mention the overpayment. In June 2004 HMRC finalised Mr and Mrs K's 2003-04 joint award, and paid arrears. It did not tell Mrs K about the outstanding overpayment. In November HMRC finalised Mrs K's single claim; the resulting award notice said she had not been entitled to tax credits from 6 April to 20 June 2003, but did not mention the overpayment.

In February 2005 Mrs K received a notice about her 2003-04 single award which said she owed £1,673.57. She contacted HMRC, which said it had mistakenly added 'responsibility end' dates for her children. It said that once the dates were removed, she would no longer have the overpayment, or else only a small one caused by the payments HMRC had made to her after June 2003. That information was incorrect. Mrs K complained to the Ombudsman that HMRC had delayed telling her about the overpayment, which she said should have been deducted from the joint award arrears. She said that repayment would cause her financial hardship.

We upheld Mrs K's complaint. Legally, HMRC cannot offset single award overpayments against joint award arrears, but Mrs K did not know that and understandably assumed that she owed HMRC nothing when arrears on the joint claim were paid. HMRC did not inform Mrs K of the overpayment until February 2005. We were satisfied that it was reasonable for her to have thought that her award was correct before then. HMRC misadvised Mrs K in March 2005: removing the responsibility end dates would have had no impact, and she had not received any payments on her single award after reporting that Mr K had moved in with her. HMRC agreed to remit the overpayment, and offered Mrs K a consolatory payment of £50 for the unnecessary worry and distress it had caused her.

7
Case Study

Cessation of bank payments left income support claimant short of food

Mr L wrote to Jobcentre Plus on 11 February 2006 asking that the means by which his income support was paid be changed from payment direct into a bank account to payment by cheque. He instructed his bank to close his account and destroyed his bank card. Jobcentre Plus did not receive Mr L's letter until 14 February, by which time it had paid his weekly payment for 13 February into his bank account. On receipt of Mr L's letter, Jobcentre Plus suspended his payments, waiting for him to say if he was going to open a new bank or Post Office account.

When the next benefit payment did not arrive as expected Mr L contacted his MP (he said he did that because in the past Jobcentre Plus had ignored some of his letters until the MP had become involved). The MP contacted Jobcentre Plus, which lifted the suspension and sent Mr L a cheque for his missing payments. Jobcentre Plus apologised to Mr L and said that a consolatory payment would be considered. The referral for a consolatory payment included a letter from Mr L to his MP, in which he described the effects of being without income support: he had no electricity and hence no heat, light or hot water. He was also unable to afford food. Jobcentre Plus accepted that maladministration had interrupted Mr L's benefit payments, but concluded that the degree of inconvenience caused did not warrant compensation. It also took account of the fact that Mr L had not contacted it about the payment problem, but instead had approached his MP. Mr L complained to the Ombudsman that Jobcentre Plus had left him without payment for three weeks, for which it had apologised but refused to give compensation.

We partly upheld the complaint. It was maladministrative of Jobcentre Plus to stop paying Mr L's benefit into his bank account but not to start paying it by cheque. It was not at fault, however, for making the 13 February payment direct into Mr L's bank account, as it had not yet received his request to change the payment method. It was reasonable, given Mr L's history of interaction with Jobcentre Plus, for him to have initially sought his MP's help. For its part, Jobcentre Plus paid insufficient attention to the facts of Mr L's deprivation when considering the consolatory payment.

Jobcentre Plus reconsidered its decision and awarded Mr L £400 for inconvenience and distress. It also agreed to apologise to him for not making a payment in the first place. Jobcentre Plus also undertook to reply promptly to any future correspondence from Mr L in line with its service standards.

Department for Work and Pensions

We reported on 98 cases relating to 118 complaints against DWP and its agencies, including 7 relating to the handling of complaints by DWP's Independent Case Examiner (ICE). We welcomed the extension of ICE in 2007 to include all of DWP's customer-facing agencies, a change which the Ombudsman has been calling for since 2003.

As in previous years, two themes running through our DWP casework in 2007-08 were mistakes or shortcomings in the administration and allocation of benefits, and failings in the handling of resultant complaints. In the case of Mr L, Jobcentre Plus changed the method of benefit payment at Mr L's request, but then left him without benefits for three weeks, leading to significant hardship. When he complained, it refused to make a consolatory payment.

In the case of Mr J, Jobcentre Plus took four and a half months to process a claim for incapacity benefit. When he complained, it awarded him £50 but refused to award him interest on his delayed payments because of an arbitrary rule on when interest calculations should begin.

Complaints are often triggered by a lack of co-ordination between different parts of the body complained against. After Mr P's wife died in 2003, his daughter enquired on his behalf to Jobcentre Plus about the possibility of help with funeral payments. Social fund staff correctly told her that he was not eligible for a social fund payment, but failed to inform her that he could claim a payment from the bereavement benefit team.

8
Case Study

Inflexible application of incapacity benefit interest rule was unfair

Mr J claimed incapacity benefit in January 2006. Although there was a complication with his National Insurance contributions record, Jobcentre Plus was aware of the problem and had been told by HMRC how to resolve it. That complication should not have added more than about two to three weeks to the time taken to decide Mr J's claim, but Jobcentre Plus took four and a half months to decide it.

After Mr J complained to Jobcentre Plus about the delay deciding his claim, it offered him a £50 consolatory payment for inconvenience but no interest to compensate for the delay in receiving incapacity benefit payments. The decision not to make an interest payment was based on guidance which said that no interest was payable for an initial period ('indicator of delay'), and that no payment would be made if the interest calculated was less than £10. In Mr J's case, incapacity benefit had an 'indicator of delay' of four months; therefore, the interest was only calculated for half a month. The amount calculated (£3.98) was less than £10 and so nothing was payable. Mr J complained to the Ombudsman that that was unfair and indicated an unreasonably low expectation of service level.

We upheld Mr J's complaint. The calculation of interest from four months after he had claimed incapacity benefit was arbitrary, and we recommended that Jobcentre Plus recalculate the interest from a date appropriate to the circumstances of the case. Based on the average time taken to clear incapacity benefit claims at that time and the particular complication that affected Mr J's claim, Jobcentre Plus agreed to start its interest calculations from six weeks after the date of his claim. He was awarded £14.96 in interest. We also considered that £50 was inadequate for the inconvenience Mr J had suffered and Jobcentre Plus agreed to award a further £100.

9
Case Study

Failure to refer widower for bereavement interview prevented benefit claim

Mr P's wife passed away suddenly in November 2003. His daughter (Mrs Q), who had also been Mrs P's carer, telephoned her local Jobcentre Plus office to report the death, and to ask if her father was entitled to any help with funeral costs. She was put through to the social fund team who told her, correctly, that her father was not entitled to a funeral payment from the social fund. She accepted what she was told and made no further enquiries. Some 18 months later Mr P was told by a recently bereaved friend that he could have been eligible for a bereavement payment (but by then he was out of time to make a claim).

Mr P asked Jobcentre Plus to review his case. It interviewed him and Mrs Q about the advice they had been given in 2003, but refused his request for a special payment. Mr P then complained to the Ombudsman; he said he had found it difficult to cope financially following the death of his wife, and the lack of a bereavement payment had added to his distress and caused him avoidable inconvenience.

We upheld the complaint. Although the social fund officer's response was correct, it was maladministration not to have signposted Mrs Q to the bereavement benefit team, who could have told her about a bereavement payment. We also found that Jobcentre Plus was maladministrative in not acting on the notification of death and not offering Mr P a bereavement interview, which was normal practice. We concluded that the guidance according to which the officers were operating restricted their ability to provide a joined-up service to customers, and had led to injustice for Mr P.

We recommended that Jobcentre Plus apologise to Mr P, award him an extra-statutory payment of £2,000 in respect of the bereavement payment plus interest (£293.28) and a consolatory payment of £200. Jobcentre Plus agreed to do so. During the course of our investigation, Jobcentre Plus revised its guidance so that the relevant sections on funeral payments from the social fund and bereavement payments cross-reference each other.

As in previous years, a high percentage of complaints against DWP in 2007-08 related to the Child Support Agency – although the number of complaints accepted for investigation was down to 18 from 68 in 2006-07. This decrease partly reflects our decision to take a more strategic approach and accept only the most appropriate cases for investigation. There have also been some signs of progress in complaint handling at the Agency, coinciding with the extended remit of ICE last year. The Agency has also published clear written guidelines in the leaflet *How do I complain about the service I get from the Child Support Agency?*. If we receive a new complaint about the Agency, we check whether it has been through the various stages of the Agency's complaints procedure, and in particular whether it has been through ICE. If it has not, then we generally refer the complaint to ICE.

Notwithstanding these improvements, we are still investigating cases that highlight serious administrative failings in past years. An example is the case of Miss D. The Agency allowed significant arrears of child maintenance to build up despite repeated requests from Miss D to resolve the problem. We note that administrative failings such as these are being addressed in the current reform of the child maintenance system with the establishment of the Child Maintenance and Enforcement Commission.

10
Case Study

Failure to address maintenance arrears led to financial hardship

Miss D complained that since December 2003 the Child Support Agency (the Agency) had failed to reassess child maintenance on three occasions, which led to a build up of arrears. She also complained that the Agency failed to take adequate action to collect the arrears from the non-resident parent. (By November 2006 the outstanding maintenance arrears owed to Miss D were £10,229.90.) She suffered inconvenience and financial hardship.

We upheld Miss D's complaint. The Agency delayed acting on, or failed to act on, three specific requests by her for it to reassess the maintenance liability, following changes in the non-resident parent's circumstances. On the occasions the Agency did reassess the maintenance liability of the non-resident parent it did not ask him to make any payments towards the arrears. In 2006 the non-resident parent appears to have gone abroad and so was out of the Agency's jurisdiction.

In the light of the evidence that the non-resident parent had always paid the amounts of maintenance that the Agency had demanded from him and had continued to pay maintenance for a period after its jurisdiction had ended, we found that he would have made the payments towards the arrears that the Agency had failed to pursue effectively. However, there was insufficient evidence that the Agency could have secured more than the £30 per week interim maintenance assessment that he paid after becoming self-employed in July 2005.

Miss D lost the opportunity to receive the maintenance she was due. At our recommendation, the Agency agreed to make her an exceptional advance payment of £6,480.16 for the arrears that it had failed to pursue effectively. It also made an additional consolatory payment of £70 (on top of £220 it had already awarded earlier for delays she had suffered) in respect of delays in assessing and collecting arrears after Miss D's first review request and for the inconvenience of having to pursue her complaint through us.

Occupational pensions

Trusting in the Pensions Promise

As was reported last year, the Ombudsman's March 2006 report on the role of government bodies in the security of final salary occupational pension schemes led to judicial review proceedings brought by four complainants who were unhappy with the Government's rejection of the findings and most of the recommendations contained in our report. As directed by the High Court in its judgment on those proceedings, the Secretary of State for Work and Pensions reconsidered the Ombudsman's central recommendation – that the Government consider whether it should make arrangements to restore the full pension entitlements of those who had lost all or most of their pensions when their scheme wound up.

As a result, on 17 December 2007 the Secretary of State announced that the Government had decided to extend the scope of the Financial Assistance Scheme. The aim of the Government's proposals was to give to all those who lost their pensions through no fault of their own, including members of solvent employer schemes, benefits that were broadly equivalent to those available under the Pension Protection Fund. These changes both greatly improved the compensation available and also extended it, beyond those members of insolvent employer schemes who were within fifteen years of retirement, to all those who have lost their pension. The relevant legislation to effect these changes is now in place. We understand that payments are now being made to some of those previously excluded from the Financial Assistance Scheme.

The Ombudsman welcomed this announcement, which constitutes full compliance with the key recommendation made in our report and which remedies the deficiencies in the Financial Assistance Scheme that were also identified in that report. The Public Administration Select Committee, in its Annual Report published on 17 January 2008, said that this *'represents a real achievement for the Parliamentary Ombudsman, the tireless campaigners, and the political process as a whole'*.

As was also reported last year, aspects of the judgment of the High Court in the judicial review proceedings were the subject of appeal proceedings, in which the Ombudsman played an active part.

On 7 February 2008 the Court of Appeal handed down its judgment, holding that, while the Ombudsman's findings were not binding on the public bodies within her jurisdiction, the relevant body must either accept such findings or establish cogent reasons for not doing so.

The special relationship between the Ombudsman and Parliament was also underlined within the judgment, which said that *'the work of the Parliamentary Ombudsman generally was both highly valued and entitled to respect'*. In addition to assisting Parliament in holding the Executive to account, the role of the Ombudsman was said to be *'vigorously to alert Parliament to an injustice which has occurred through maladministration'*.

Home Office

Border and Immigration Agency

We reported on 52 complaints about the Border and Immigration Agency (now the UK Border Agency) in the year.

In conjunction with the Government's Green Paper *The Path to Citizenship*, the Agency published a series of consultation questions in February 2008 on reforming the immigration system. While the specific questions did not fall within the remit of the Ombudsman, she did respond with some general observations and recommendations about the need to simplify the system. The Ombudsman welcomed the Government's aim of simplifying the legal framework for immigration. She has long been concerned that asylum seekers and immigration detainees do not have access to clear and comprehensive information about the avenues of complaint that are available to them in the UK. This problem is often compounded by flawed processes, avoidable delays and systemic failings as the case studies of Ms H, Mrs F and Mr E amply demonstrate.

In responding to the consultation, the Ombudsman emphasised the need to keep in mind two key principles: the need for good administration and the need for good complaint handling. She noted that the Green Paper states that simplification is important in helping to increase the efficiency of the decision-making process, thereby reducing delay and the risk of mistakes. While agreeing with this, she emphasised the need to have a good complaint handling system in place to deal with mistakes when they do happen, and stressed that effective complaint handling will help increase public confidence in the system.

11
Case Study

Border and Immigration Agency took five months to correct simple mistake

Ms H applied for indefinite leave to remain in January 2005. The Border and Immigration Agency (the Agency) granted leave in August 2006, and despatched the status documents to Ms H on 5 October. Ms H promptly returned them to the Agency's Croydon office, as it had attached her residence permit to her daughter's immigration status document and vice versa. She said that her cancelled travel document had not been enclosed although the covering letter had said that it was. The Agency received the package on 11 October and sent it to its Liverpool office. No note was made of its arrival.

Ms H asked her MP for help and on 4 January 2007 the MP's office told the Agency that Ms H urgently needed her status papers. The Agency could not find Ms H's papers and conducted a search. It requested permission to destroy the original status documents unseen so that replacements could be issued. Permission was granted and corrected documents were issued to Ms H on 5 March.

Ms H complained to the Ombudsman about the Agency's delay in ruling on the leave applications, the time taken to correct the mistake over the status papers and the failure to return her cancelled travel document. She said she had suffered inconvenience and distress, her studies had been disrupted (she could not enrol for a particular course as she had neither her passport nor status papers), and she was concerned that she might have problems in future obtaining a new travel document as she could not produce her previous one.

We upheld Ms H's complaint. At the time of her application, the Agency had received a number of similar applications, which caused delay. Her file was twice sent to storage before a decision had been made and it was not allocated to a caseworker until some 19 months after the Agency had received it. The Agency's mistake over the status papers was unfortunate and did not amount to maladministration, but it handled matters poorly after that. It received the incorrect status papers, but what happened next is unclear since there was no record of their arrival in Liverpool. The Agency only took meaningful action when Ms H's MP stressed the urgency of her case and took five months to correct a simple mistake.

The Agency apologised to Ms H for its mistakes and awarded her £200 in recognition of the inconvenience caused. It accepted it had mislaid her cancelled travel document, and confirmed that in writing. (The letter will enable Ms H to prove why she no longer has her old travel document).

12
Case Study

Delay processing application caused woman to miss a funeral and wedding

In June 2004 Mrs F and her husband applied for leave for her to remain in the UK on the basis of her marriage to a UK resident. In June 2005 Mr F wrote to tell the Border and Immigration Agency (the Agency) that Mrs F needed to travel abroad as his father had recently died. The Agency received the letter but took no action. Nor did it respond to letters it received in February and March 2006 from Mrs F's solicitors querying the delay processing the application. Throughout July the solicitors sent further letters of complaint about the delay and requests for a reply. On 14 August the solicitors told the Agency that unless Mrs F's application was decided by 3 September, they would refer matters to the Ombudsman.

The solicitors and the Agency continued to exchange correspondence. In a letter dated 12 October, the solicitors complained that Mrs F's application had been handled appallingly. They said she had made plans to travel to Nigeria for urgent family reasons by 15 December and asked that her application be dealt with immediately. On 20 December the Agency noted that it was unable to make a decision because her application form and documents, including both her and her husband's passports, were not on the file.

Mrs F complained to the Ombudsman in January 2007 that the delays deciding her application for leave had led to her missing a funeral and her sister's wedding. Furthermore, the Agency had not responded to her solicitors' letters and had lost her passport and other documents. In June 2007 the Agency granted Mrs F two years' leave to remain as a spouse of a UK resident.

We upheld Mrs F's complaint. The Agency took no substantive action on her application between July 2004 and February 2007; it lost Mr and Mrs F's passports and other documents; and did not respond to the solicitors' correspondence. The Agency offered Mrs F consolatory payments totalling £250 for the delay and failure to reply to her solicitors' correspondence, and a further £1,250 for Mr and Mrs F being unable to attend the funeral. The Agency agreed to compensate them for the cost of replacing their passports, and to make a consolatory payment in respect of having missed the wedding, on receipt of suitable supporting evidence. It agreed to apologise to Mrs F for its failings.

13
Case Study

Mishandled correspondence and delay caused stress and inconvenience

Mr E entered the UK in June 2004 and claimed asylum. The Border and Immigration Agency (the Agency) refused his asylum claim, but as an unaccompanied minor it granted him discretionary leave to remain in the UK until his 18th birthday in April 2005. On 1 April 2005 solicitors wrote to the Agency on Mr E's behalf to claim asylum, and on 6 April they applied to extend his discretionary leave to remain. The Agency did not acknowledge that application. In May the solicitors asked the Agency to acknowledge the application and for an indication of how long the application would take to process. The Agency replied that Mr E's file was in a queue waiting for an asylum interview to be arranged. The solicitors say they did not receive this letter.

In January and February 2006 the solicitors twice wrote to the Agency asking it to issue Mr E with a replacement Application Registration Card (which he had lost) or to interview him. The Agency did not reply to either letter. In June the solicitors complained to the Agency about the delay deciding the application, and its failure to confirm that the conditions attached to the previous grant of leave would continue while it considered the application. The Agency placed the letter on file unactioned because it was not addressed to its complaints unit. Two further letters of complaint went unanswered.

Mr E complained to the Ombudsman about the Agency's delay in deciding his application of 6 April 2005 and failure to provide a written acknowledgement. He said the uncertainty about his immigration status had led to anxiety and mental health problems, and inconvenience dealing with organisations such as colleges and housing providers. We put Mr E's complaint to the Agency, which decided, in light of its mishandling of the correspondence, to interview him and decide his application earlier than would have otherwise been the case. Mr E's application was refused in March 2007.

We upheld Mr E's complaint. The Agency did not acknowledge his application, so he could not prove he was in the UK legitimately, and took nearly two years to decide the application. It failed to respond to complaints and important correspondence relating to someone in a vulnerable situation. The Agency apologised to Mr E and offered a consolatory payment of £150 in recognition of the stress and inconvenience caused. We accepted that this was a reasonable remedy because we did not have evidence to support the full extent of the injustice claimed by Mr E.

Other Departments – Special reports to Parliament

Ministry of Defence
'A Debt of Honour'

As was also reported last year, the Government eventually accepted and implemented all of the Ombudsman's recommendations contained in our July 2005 report *'A Debt of Honour'*, which concerned the administration of an ex gratia scheme for those British groups who had been interned by the Japanese during the Second World War.

The scheme has now been reviewed, the eligibility criteria revised, and compensation payments have been paid as a result both of the Ombudsman's report and of the outcome of court proceedings in relation to allegations of race discrimination in the administration of the scheme and in the application of its eligibility criteria.

However, we continue to receive enquiries and complaints from people dissatisfied with these outcomes. Some of those enquiries and complaints raise new issues about the way in which the scheme now operates or about how decisions about eligibility for the associated new compensation payments are being made.

The Ombudsman remains concerned that outstanding issues remain to be resolved regarding the appropriate scope for the scheme and that complaints continue to be made about it.

We will continue to monitor developments and the Ombudsman envisages that further dialogue with the Ministry of Defence might be necessary in respect of these outstanding issues.

Department for Business, Enterprise and Regulatory Reform
Put together in haste: 'Cod Wars' trawlermen's compensation scheme

The Ombudsman's report of her investigation into the Icelandic Water Trawlermen's Compensation Scheme, *Put together in haste*, was published in February 2007 and contained five recommendations, all of which were accepted by what was then the Department for Trade and Industry. The Department took action to comply with the first and fifth recommendations. However, it has yet to comply with the second recommendation that it should undertake a review – which it said at the time it intended to start immediately – of the eligibility criteria and scheme rules to ensure that they were consistent with the policy intention underlying the scheme. The third and fourth recommendations cannot be implemented until the review has taken place.

The Ombudsman has been concerned for some time about the extremely slow progress in complying with her recommendations and in May 2008 she wrote to the Permanent Secretary (at what is now the Department for Business, Enterprise and Regulatory Reform) to express her growing concern. In response, the Permanent Secretary has told the Ombudsman that the Department has almost completed its analysis of the best way forward in relation to the scheme; and that, whilst it recognises that this has taken a considerable time, this is an extremely complex matter and it is important to get it right. The Department hopes that Ministers will be in a position to make a statement on the scheme in October.

The Ombudsman will continue to monitor the situation closely and will report further to Parliament if necessary.

Department for Environment, Food and Rural Affairs
The introduction of the ban on swill feeding

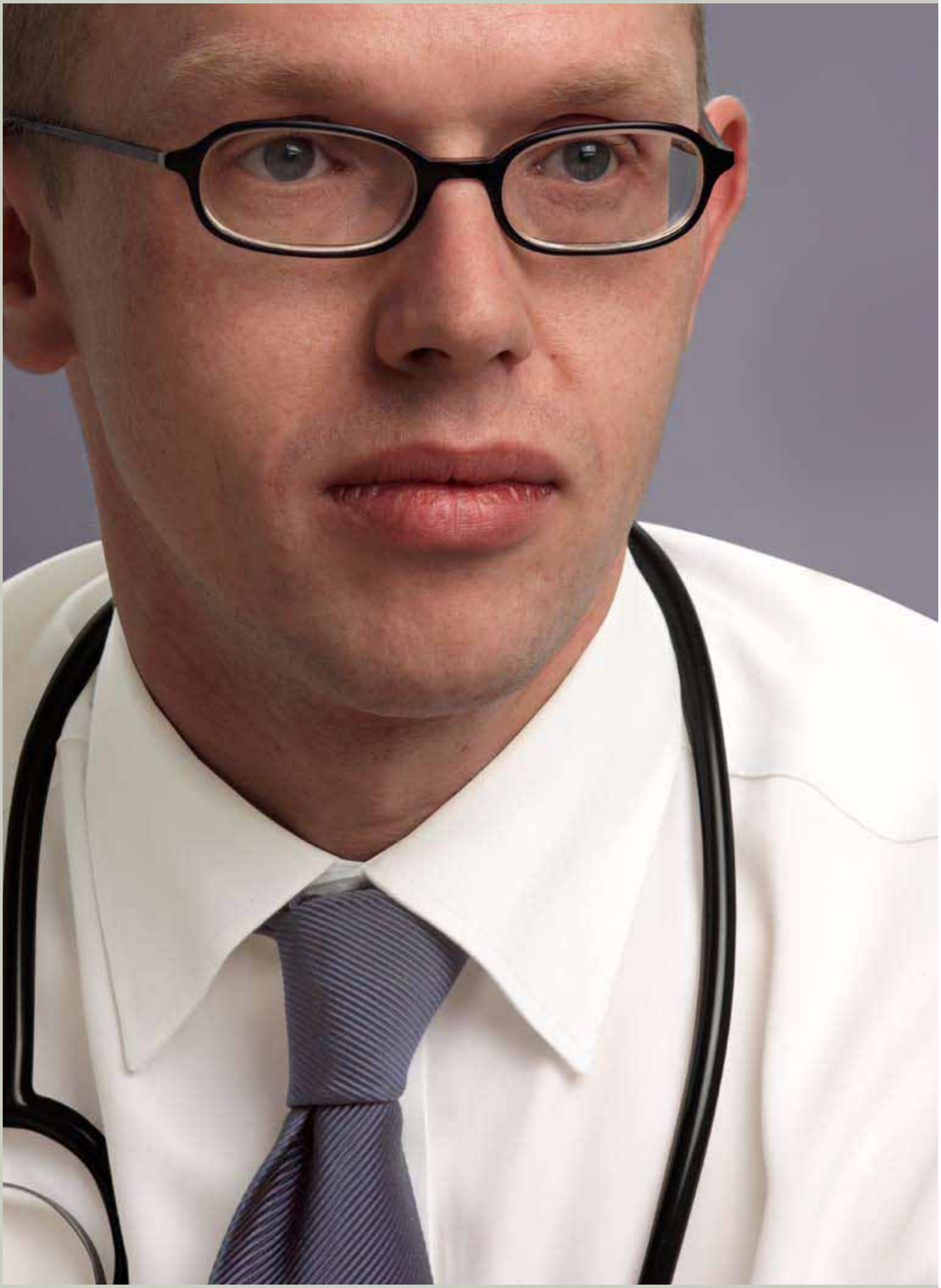
In December 2007 we published the report of our investigation into a complaint by the Associated Swill Users against the Department for Environment, Food and Rural Affairs about the ban on swill feeding introduced after the outbreak of foot and mouth disease in 2001. Although the complaint was not upheld, the Ombudsman decided that the report should be put into the public domain because of the level of interest in the subject matter, and in particular the link to the outbreak of foot and mouth disease.

Since the report's publication, the Department's Permanent Secretary has written to describe the analysis and recommendations in the report as *'very useful'* in informing the development and strengthening of the Department's business systems, and to outline improvements both to management and storage of data and to the keeping of records of key advice supporting changes in legislation.

Her Majesty's Treasury (et al)
Equitable Life: a decade of regulatory failure

Work continued throughout 2007-08 on the investigation into the prudential regulation of Equitable Life during the period prior to 1 December 2001. The Ombudsman's report of the investigation was laid before Parliament and published in July 2008. The report can be found on our website at www.ombudsman.org.uk

We await the Government's response to the report and the Ombudsman will do everything she can to assist Parliament in its consideration of the report and of the Government's response to it and also to assist the European Parliament in its further consideration of the same issues.



The National Health Service

In 2007-08 we received 4,011 enquiries related to 4,257 complaints against the National Health Service.

We accepted 703 cases for investigation and reported on 636 investigations. 49% of complaints were upheld in full or in part.

In addition to our casework, a major focus in 2007-08 was on preparing for our role in the new NHS system for handling complaints, which begins in April 2009.

Enquiries

Figure 4 shows the top ten types of health body and individuals complained about. Under the current NHS complaint handling arrangements most health complaints should come to us after they have been considered by the Healthcare Commission – so it is no surprise that over 40% of health-related complaints – 1,832 – were about the Commission.

Interventions

There is a growing category of complaints where we seek to achieve resolution without recourse to full investigation. We call these 'interventions' and we closed a number of cases in this way during 2007-08. In case study 14, Mr C's four-month wait for a medical appointment was ended promptly by our intervention.

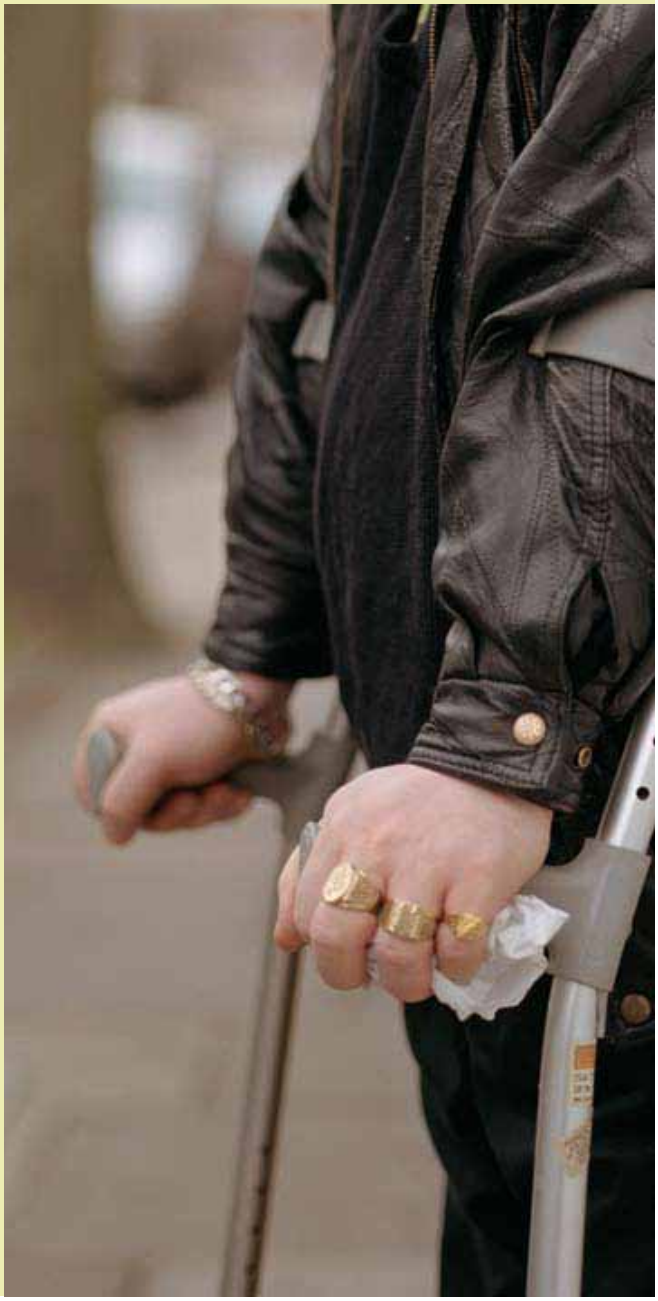
Figure 4
Top 10 types of health body or individual complained about (apart from the Healthcare Commission)

	Received
NHS Hospital, Specialist and Teaching Trusts (Acute)	715
Primary Care Trusts	442
General Practitioners	360
Strategic Health Authorities	314
Foundation Trusts	242
Mental Health, Social Care, Learning Disability NHS Trusts	152
General Dental Practitioners	144
Ambulance Trusts	16
Care Trusts	12
Special Health Authorities	12

14
Case Study

Intervention ended wait for foot appointment

Mr C complained first to the Healthcare Commission and then to the Ombudsman about the fact that he would have to wait four months for an appointment with a podiatrist (four months was the average waiting time for routine podiatry care). During our consideration of Mr C's complaint, we contacted Brent Teaching Primary Care Trust to explain his ongoing concerns and to ask when he was likely to receive an appointment with the podiatrist. As a result of that intervention, the Trust contacted the Senior Podiatrist who agreed to contact Mr C by telephone on a specific date to offer him an appointment.



Investigations

Formal investigations involve detailed and thorough examination of the facts of a case. They often run to months, or occasionally years, of work. They are also in a minority, because most complaints referred to us are not considered appropriate for full investigation.

We accepted 703 cases for investigation relating to 737 complaints. 70 of these cases related to continuing care.

Figure 5 shows the number of complaints we accepted for investigation by type of NHS body or individual, except for the Healthcare Commission (624).

We reported on a total of 636 investigations in 2007-08, of which 93 were about continuing care. Overall, we upheld 38% of complaints in full and partly upheld a further 11%, although we upheld, in full or in part, 56% of continuing care complaints. Figure 6 shows the number of complaints we reported on by type of NHS body or individual, and the outcomes of those complaints.

Figures 20, 21 and 22 in Chapter 4 of this report give full details of all our investigations of complaints about NHS bodies and individuals and their outcomes, broken down by Strategic Health Authority area. There are separate tables for continuing care complaints, other complaints, and all health complaints because continuing care cases were still a substantial component of our work in 2007-08. Further detail on continuing care cases is given on page 45.

Figure 5
Health complaints accepted for investigation by type of body or individual

	Accepted for investigation
Strategic Health Authorities	70
NHS Hospital, Specialist and Teaching Trusts (Acute)	13
Primary Care Trusts	12
Foundation Trusts	8
Mental Health, Social Care, Learning Disability NHS Trusts	5
General Practitioners	5

Figure 6
Health investigations reported on by type of body or individual

	Reported on	Fully upheld	Partly upheld	Not upheld
Healthcare Commission	508	35%	10%	55%
Strategic Health Authorities	93	52%	4%	44%
General Practitioners	21	24%	29%	48%
NHS Hospital, Specialist and Teaching Trusts (Acute)	21	43%	24%	33%
Primary Care Trusts	19	37%	32%	32%
Foundation Trusts	18	50%	17%	33%
Mental Health, Social Care, Learning Disability NHS Trusts	4	25%	25%	50%
General Dental Practitioners	2	100%	0%	0%
Ambulance Trusts	1	100%	0%	0%
Total	**687**	**38%**	**11%**	**51%**

Individual and public benefit

Our health work during 2007-08 clearly illustrated the dual aspect of the Ombudsman's role in achieving remedy in individual cases, while also providing wider public benefit. This wider benefit stems from the effective use of our evidence base and our expertise in providing a high quality complaint handling service, together with an acknowledged reputation for independence and impartiality. This enables us to provide expertise in good administration and good complaint handling, drive improvements in the delivery of healthcare and inform public policy, demonstrating that the Ombudsman not only provides a retrospective remedy for injustice or hardship resulting from maladministration or service failure, but also seeks to secure prospective improvements in the wider public interest.

In addition to our casework, a major focus in 2007-08 was on preparing for our role in the new NHS system for handling complaints, which begins in April 2009.

In March 2005 we published *Making Things Better? A report on reform of the NHS complaints procedure in England.* This informed a Department of Health consultation paper, *Making Experiences Count, a new approach to responding to complaints,* published in June 2007, which set out proposals for improving and integrating the handling of complaints about health and social care. Now, the Department has developed a new system for handling complaints, which will launch in April 2009. We fully support these new arrangements, which we believe will enable complaints against the NHS to be dealt with more quickly, efficiently and fairly. We say more about the new arrangements on page 39.

A Framework of Principles

After wide consultation, in October 2007 we published our *Principles for Remedy*, which offer complementary guidance to our *Principles of Good Administration*, published in March 2007. The *Principles for Remedy* follow the same six Principles as our *Principles of Good Administration*:

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

Principles for Remedy gives our view of the Principles that should guide NHS bodies and individual practitioners in providing remedies for injustice resulting from their maladministration or service failure. We want NHS bodies and individuals to be fair and take responsibility, acknowledge failures and apologise for them, make amends and use the opportunity to improve their services.

During 2007-08 we developed the third in our series of Principles, which we have been consulting on in recent months and will publish in autumn 2008. Our *Principles of Good Complaint Handling* are based on the same six core Principles as our *Principles of Good Administration* and *Principles for Remedy*. With them we aim to ensure that NHS bodies and individuals understand how we expect complaints to be handled, and that complainants understand how we will consider their cases. As with the existing Principles, we hope that they will prove useful to both complaint handlers and complainants.

Poor complaint handling by NHS bodies and individuals was a recurrent theme across our health investigations in 2007-08, and one we refer to frequently in the pages that follow. Often, the failure to provide an adequate remedy is an element of poor complaint handling, and is a significant factor in the complainant's decision to refer the complaint to us for investigation, as in the following two examples.

Poor complaint handling

In the case of Mr P an NHS Trust (the Trust) failed to explain adequately why it refused to respond to two complaints he made on behalf of a friend suffering from Alzheimer's disease. Nor did the Trust demonstrate that it had considered the NHS (Complaints) Regulations or the relevant legislation in reaching its decision.

15
Case Study

Patient confidentiality was no reason to withhold response

In October 2006 Mr P made two complaints to Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust (the Trust) on behalf of his friend of many years, Mr T, who suffers from Alzheimer's disease and so was unable to make the complaints himself. Mr P's complaints were about the care and treatment provided by the Trust to his friend, and about the suitability of a nursing home, which Mr P believed was contrary to Mr T's best interests and against his wishes. The Trust told Mr P that they could not respond to his complaints, citing the need to protect patient confidentiality and the Data Protection Act, but would take up the matters he had raised with Mr T's sister, as next of kin.

Mr P complained to the Ombudsman that the Trust's refusal to respond to his complaints meant his concerns about Mr T's care and treatment remained unanswered. We upheld Mr P's complaint. While patient confidentiality is a legitimate consideration when deciding whether a representative is a suitable complainant, the Trust did not adequately explain to Mr P why it should not respond to his complaints. Nor did it demonstrate that it had adequately considered the NHS Complaints Regulations or the relevant legislation in reaching its decision. We found no evidence that the Trust had established whether Mr T was capable of providing consent for the release of confidential information to Mr P, or considered if Mr T had given **implied** consent to release. There was no evidence that the Trust had considered whether there was any overriding public interest reason for disclosing information to Mr P, or if any aspects of his complaint could be responded to without releasing confidential information.

The Trust agreed to apologise to Mr P for the failings we had identified and to reconsider his request to bring a complaint on Mr T's behalf, taking account of the issues we had raised in our report (in particular the need to provide Mr P with written reasons for its decision).

16
Case Study

Complaint about cancer treatment was not properly handled

In 2000 Mrs S's husband was diagnosed with prostate cancer and had radical surgery. Although the surgery was performed privately, the majority of his pre- and post-operative care was provided by the University Hospitals of Morecambe Bay NHS Trust (the Trust). Serious post-operative complications necessitated further operations and a long stay in hospital. Mrs S considered that her husband had been poorly advised about treatment options and she complained to the Trust. An Independent Review Panel (the Panel) considered her complaint and made several recommendations, some of which related directly to the clinical practice of the Consultant Urologist responsible for Mr S's care.

Mrs S complained to the Ombudsman that the Trust had not done more to resolve her complaint prior to the Panel, and had failed to inform her of the action it had taken, or planned to take, to implement the Panel's recommendations.

We upheld Mrs S's complaint. She did not receive an adequate response to her complaint in a timely manner. The Trust did not offer her a meeting to discuss her concerns, and failed to bring the local resolution phase of the NHS complaints procedure to an end to allow her to escalate her complaint. It also allowed all aspects of Mrs S's complaint to be investigated under the NHS complaints procedure, when it knew that some of her concerns about the Consultant's practice needed to be reviewed through a different process. The Trust failed to give Mrs S details of the action it had taken, or planned to take, to implement the Panel's recommendations, or reassure her that it was taking appropriate action to implement them. She was left feeling that she had no other recourse than to approach the Ombudsman and the General Medical Council to resolve her complaint.

The Trust agreed to apologise to Mrs S for the failings we had identified and to send her details of the action taken to implement the Panel's recommendations that did not relate to the Consultant's personal practice. It also agreed to use the case as a learning opportunity to assist it when considering what parts of a complaint should be investigated under the NHS complaints procedure, and to make a payment to Mrs S of £500 in recognition of the worry and distress its poor complaint handling had caused.

In the case of Mrs S, we found that the hospital where her husband was treated for prostate cancer failed to give an adequate and timely response to her complaint about his care. It also failed to inform her of the action it had taken in response to the recommendations from an Independent Review Panel.

A new approach to NHS complaint handling

The Ombudsman has argued for improvements in the NHS complaints procedure for many years and is pleased to see the changes that will be introduced from April 2009.

Under the existing three stage system, the second stage is provided by the review function of the Healthcare Commission, with a possible third stage when a case is referred to the Ombudsman. The new system will have only two stages: a complainant who remains dissatisfied after a case has been considered locally will be able to refer the complaint straight to the Ombudsman. These reforms should reduce delays for both the complainant and the NHS service provider, and deliver more timely, responsive and effective outcomes. We are working closely with the Healthcare Commission to bring about a smooth transition to the new system.

A further objective of the new system is to achieve greater alignment between the NHS and the social care system. We are working closely with the Local Government Ombudsmen to make sure that there is a fully integrated approach to complaints that cross boundaries between health and social care (see *Injustice in Residential Care,* page 53).

The new system will also enable patients with complaints about primary care providers (GPs, dentists, opticians and pharmacists) to complain directly to the Primary Care Trust if they choose, rather than to the service provider. We know that for many patients, complaining to a practitioner with whom they have an existing relationship can be difficult.

The importance of local resolution

In the short term we expect to see an increase in the number of enquiries we receive and cases we accept for investigation under the new arrangements – and we are planning for that. In the longer term we will want to see a reduction in the number of complaints referred to us as a result of improved complaint handling at local level.

Complainants often comment to us about the length of time it has taken to get to the end of the existing NHS complaints procedure. In many of the cases we investigate, delay is identified as a particular cause of complaint. It is not uncommon for us to investigate events that occurred two or three years ago, because the cases have taken that long to reach the Ombudsman after consideration by the NHS.

Our experience, supported by research commissioned by the Department of Health for its consultation paper *Making Experiences Count,* makes clear that complainants want their cases to be resolved quickly and close to source. Clearly, timely and effective local resolution of complaints should be the guiding principle for all bodies within the Ombudsman's remit.

Many of the cases we investigated in 2007-08 illustrated serious failings at local level. In the case of Mrs Y a complaint about the prosthetic service provided to amputees by her Primary Care Trust was upheld by an Independent Review Panel. The Trust agreed to make several changes to its procedures, but then failed to keep Mrs Y informed about their implementation.

The need for local leadership

Improved local resolution of NHS complaints will not come about without strong leadership at a senior level in Trusts and General Practices. Board members, chief executives and senior practitioners need to create a culture that welcomes complaints and actively seeks to resolve them, dealing with people fairly and being willing to learn from mistakes and service failures. Many of the cases of poor complaint handling that we investigate show why this strong, focused local leadership is so necessary to drive improvements. In each of these cases, strong local leadership, a culture of openness towards complaints and a determination to put things right could have prevented distress to those involved.

In the case of Mrs G we recommended compensation by the Trust and the Healthcare Commission following the poor handling of a complaint about the care and treatment of her daughter, who died after surgery. We found that the Trust's response to the Commission's recommendations was inadequate, and that its actions had caused Mrs G to suffer further distress.

We also investigated the case of Dr R, a GP who retired on health grounds after a poorly handled investigation by two Trusts of a complaint against her. We recommended substantial financial compensation by way of remedy, and she received a total of £25,000.

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Case Study

Trust failed to update amputees on service improvements

Mrs Y, an amputee, was concerned about the prosthetic service provided on the Isle of Wight, to the extent that she felt her care had been seriously compromised. Her concerns included a lack of prosthetic expertise, the lack of a consultant-led multidisciplinary team, and the availability of information, protocols or guidelines around treatment options. She made a complaint to the Isle of Wight Primary Care Trust (the Trust), which ended with an Independent Review Panel in January 2005. The Panel found that Mrs Y's complaint was justified and made several recommendations which the Trust agreed to implement. The Trust told Mrs Y that it was committed to implementing the recommendations. It also carried out a Prosthetic Services Review.

Mrs Y complained to the Ombudsman that although she had contacted the Trust on a number of occasions, it had not adequately communicated with her about how it would implement the Panel's recommendations, and had given her no official reassurances that appropriate changes to the service would be made. She hoped that her complaint would lead to improvements for amputees with complex needs living on the Isle of Wight.

We fully upheld Mrs Y's complaint. The Trust accepted it had not kept Mrs Y formally informed and updated about the implementation of the Panel's recommendations. Furthermore, Mrs Y's complaint to the Trust had been made personally, and the Trust had wrongly assumed that she had been kept updated about progress by the Artificial Limb User Group.

The Trust gave us a copy of the Prosthetic Services Review report and the Prosthetics Action Plan, which our advisers considered contained useful recommendations. The Trust also acknowledged the need to commission specialist mainland services for complex cases, such as that of Mrs Y, and told us that a meeting had been held with the staff of a specialist centre in Bournemouth. Arrangements for Mrs Y to be seen there were also progressing. The Trust agreed to apologise to Mrs Y for the failings we had identified, and to arrange a meeting with her to address any remaining concerns that she had.

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Case Study

Inadequate response to recommendations

Ms G was 42 when she had a stroke in February 2002 and was admitted to hospital. She had a pulmonary embolus (a blood clot on the lung) and was prescribed Warfarin (an anticoagulating drug) which was stopped after six months. Tests were carried out to determine her blood clotting levels and to search for a patent foramen ovale (a hole in the heart).

After review as an out-patient, Ms G was discharged from care but was readmitted in August 2002 and was found to have another pulmonary embolus. She was referred for an MRI scan which was due to take place in March 2003 but, before this happened, she moved house. She was subsequently diagnosed elsewhere as having pulmonary hypertension and a large patent foramen ovale. She was transferred to Papworth Hospital for treatment but died shortly afterwards.

Ms G's mother, Mrs G, complained in November 2003 about the failure to diagnose pulmonary hypertension at an earlier stage. Mrs G had a meeting with Trust staff in April 2004, but this failed to resolve matters. In September 2004 Mrs G complained to the Healthcare Commission, which took clinical advice from a Consultant Cardiologist, who found a number of failings in the care provided to Ms G.

In April 2006 Mrs G again complained to the Commission, which said that the Trust had complied with most of its recommendations, but asked it to respond on the issue of the review of guidelines for management of pulmonary embolism. The Trust sent a further reply to Mrs G in June 2006 which made no acknowledgement or apology for the failings identified by the Commission.

Mrs G complained to the Ombudsman in September 2006. The complaints investigated by the Ombudsman were that the Trust had failed to respond adequately to the Commission's recommendations following its investigation, and the Commission had refused to take any further action despite that failing by the Trust.

We found that the Commission had carried out an appropriate initial review of Mrs G's complaint, but that the Trust's response to the Commission's recommendations was inadequate. The Commission had failed to properly consider Mrs G's subsequent complaint about the Trust's response. The Trust's actions had caused Mrs G to suffer distress and delay in receiving the explanation and response to which she was entitled.

As a result of the Ombudsman's recommendations, the Trust made a payment of £500 to Mrs G in the light of the serious failings in its complaint handling and to recognise the additional distress caused to Mrs G following the Commission's review. It acknowledged and apologised for the failure of care towards Ms G. It also acknowledged other failings in the conduct of the case and offered explanations for these. The Commission wrote to Mrs G to apologise for the failings identified by our report.

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Case Study

Poor complaint handling led to GP's retirement on health grounds

On 3 September 2002 an altercation occurred between Mrs B, Dr R and a nurse while Mrs B was attempting to register as a patient at the practice where Dr R worked. On 6 September Mrs B wrote to the Chief Executive of Medway Primary Care Trust (Medway) to complain about Dr R. On 16 September Medway asked Dr R to respond to Mrs B's complaint letter and informed Mrs B that she could request an Independent Review of her complaint if she was dissatisfied with the practice's eventual response. Mrs B replied that she had already received a response from the practice, which she felt was unsatisfactory. Medway told Mrs B that she now had the right to request an Independent Review, but did not say they had already asked Dr R to respond direct to her.

On 2 October 2002 Dr R replied personally to Mrs B's complaint, apologising for the delay in responding, caused by her absence on leave, and setting out her view of the incident. After a conciliation process failed to resolve the complaint, Mrs B requested an Independent Review of the case. Responsibility for arranging this was delegated to Kent Primary Care Agency, which operated under the management of the Dartford, Gravesham and Swanley PCT (now West Kent PCT).

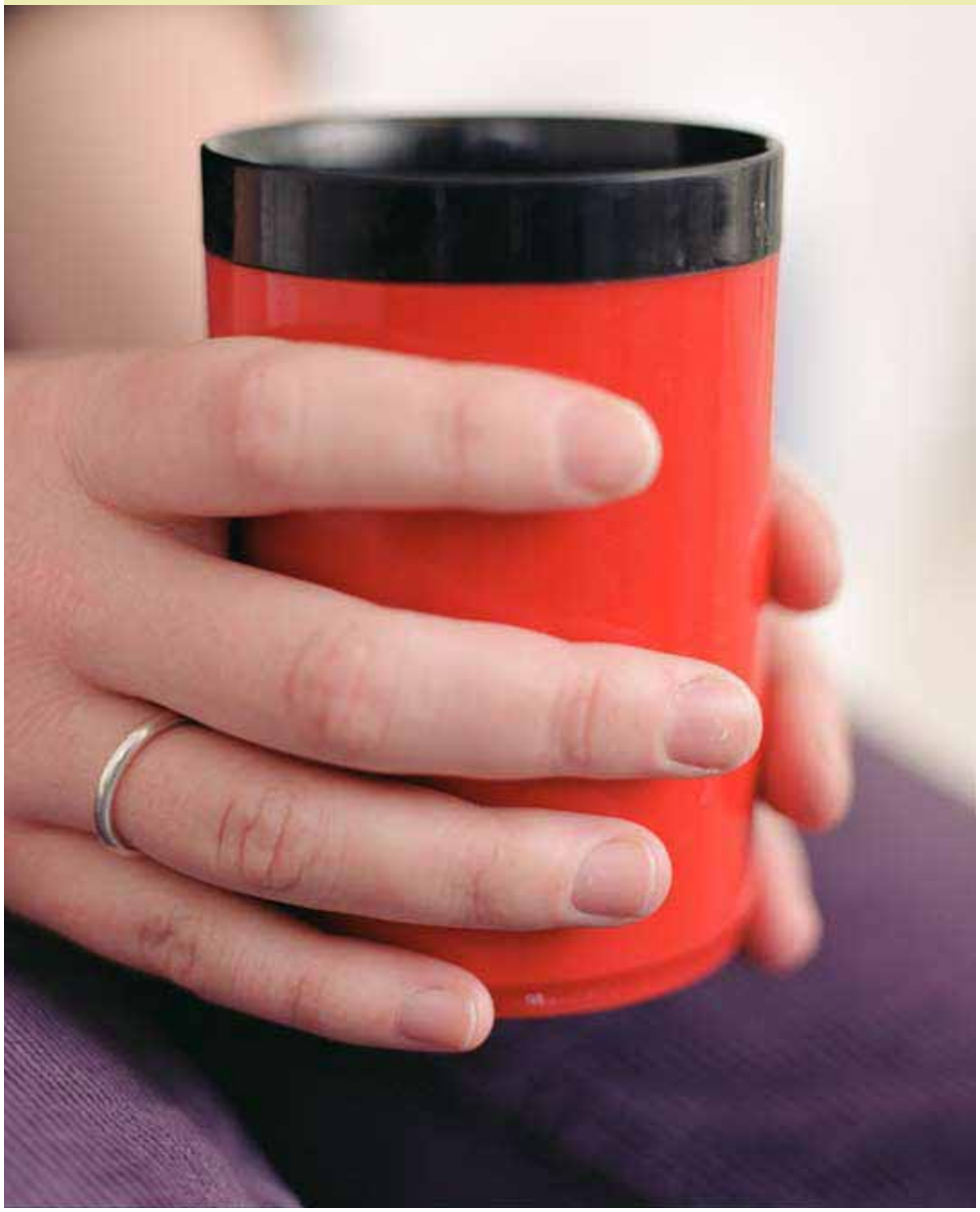
The Independent Review Panel (the Panel) met in June 2003 and partly upheld Mrs B's complaint. It said that Dr R had not breached her Terms of Service for General Practitioners, because Mrs B had not been registered with the practice. The Panel's report noted that the complaint arose out of Mrs B's attempts to register, but nonetheless said that '*such a complaint falls within the guidelines of the Health Service's Complaints Procedure*'. Dr R's mental state was such that the day of the hearing was her last day in general practice. She took sick leave and was admitted in September to a psychiatric hospital with bipolar disorder. She retired from general practice on health grounds in March 2004.

Dr R complained to the Ombudsman in August 2003, wanting an investigation into the process that had led to the Panel sitting at all. She felt she had been the victim of a '*witch hunt*' and said that the Trusts' mishandling of the complaint against her had cost her her career, and significantly disrupted her personal and family life.

Our investigation found that key documents had not been sent to Dr R in a timely manner and that Medway did not inform Dr R that they had told Mrs B that she could ask for a review despite asking Dr R to provide a local resolution letter. Dr R's letter to Mrs B was unreasonably dismissed throughout the investigation because it arrived very slightly late, despite valid reasons for the delay. Both Trusts repeatedly failed to answer Dr R's reasonable questions about whether they had considered her letter to Mrs B, and whether Mrs B was even entitled to pursue a complaint under the NHS complaints procedure. The Trusts' investigation lacked

a sense of perspective and proportionality. It was driven purely by process, with an absence of overall leadership and guidance to determine whether the progress and direction of the investigation were appropriate to the nature of the complaint. We concluded our investigation in May 2007 and upheld Dr R's complaint.

The two Trusts involved in the complaint agreed to pay the sum of £25,000 to Dr R to remedy the significant injustice to her, and to write personally to her to apologise for their failings. They also agreed to review their existing complaint handling procedures in the light of our investigation.



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Case Study

Serious failings highlighted need for review of care

Mr Z, aged 74, was admitted to Gloucester Royal Infirmary as an emergency in August 2002 with pneumonia. He was treated in the Intensive Treatment Unit until the end of August when he was transferred to a respiratory ward. He later contracted MRSA, developed diarrhoea and was found to be infected with C.difficile. Mr Z was transferred to Standish Hospital at the start of October, where he suffered with recurrent C.difficile infection. Mr Z died in November 2002, with the cause of death noted as respiratory failure.

Mrs A, Mr Z's daughter, questioned whether the Trust's actions had contributed towards his deterioration and death through failings in his care and inadequate levels of hygiene. She also questioned the accuracy of the death certificate. Mrs A believed that Mr Z had been caused undue suffering and stress during his admission and that their family had been caused unnecessary distress.

Mrs A complained to Gloucestershire Hospitals NHS Foundation Trust (the Trust) in March 2003, which responded in July 2003. A local resolution meeting was held in August 2004. Mrs A was unhappy with the action taken by the Trust and complained to the Healthcare Commission in October 2004. After conducting its own investigation, the Commission said in May 2006 that it would take no further action as it was satisfied with the Trust's actions and responses. Mrs A asked us to investigate all aspects of her complaint against both the Trust and the Commission.

Although we did not uphold complaints about specific aspects of Mr Z's medical care, we found that, when taken in the round, the evidence we saw pointed to serious failings in the Trust's service to Mr Z and his family. These included a lack of monitoring while Mr Z waited to be transferred from the Intensive Treatment Unit and a delay in carrying out a medical review. We also found there had been extremely poor nursing care in relation to care planning, communication, pain management, infection management, patient privacy and dignity, and monitoring of fluid intake/output.

We concluded that Mrs A's complaint should have prompted a wider review of nursing care which may have led to a more co-ordinated approach to implementing improvements and, in turn, provided reassurance for Mrs A that her complaint was being taken seriously. We found maladministration in the Commission's handling of Mrs A's complaint, including failure to seek clinical advice, not providing her with regular updates and failure to assess the priority of the case, which had exacerbated her worry and distress.

The Trust agreed to write to Mrs A and her family to acknowledge and apologise for the failings identified, and to review the areas where there had been serious failings. It agreed to provide Monitor (the body that authorises and regulates NHS Foundation Trusts) with information to demonstrate that its practices in the areas where we had identified serious failings were in line with current standards, and to report back to Mrs A on the action taken in response to our recommendations. The Commission agreed to write to Mrs A and her family with an apology and pay £250 compensation in recognition of the worry and distress caused by its poor complaint handling.

Mr Z was an elderly patient who died during an in-patient admission. Our investigation found that the NHS Foundation Trust providing treatment failed to undertake a wider review of care, which would have led to a more co-ordinated approach to implementing improvements.

Applying the *Principles for Remedy*

Our *Principles for Remedy* set out how NHS bodies and individual practitioners should put things right when injustice or hardship results from maladministration or poor service. We see far too many examples of cases where the NHS has failed to apply these Principles.

Despite the power of an apology when sincere and well timed, providers and practitioners are too often reluctant to apologise when something goes wrong. As the case of Mrs M demonstrates, an apology is often an important first step to remedy. As a result of our recommendations in Mrs M's case the Trust and the Healthcare Commission, which investigated the case before it was referred to the Ombudsman, agreed to apologise to Mrs M for their shortcomings and the injustice she had suffered. Just as importantly, the Trust also gave her an assurance that lessons had been learnt from her complaint.

Continuing care – bringing matters to a conclusion

It is the responsibility of the NHS to provide funding for the long term continuing care of people who need it because of accident, illness or disability. But for many years there has been considerable difficulty in deciding fairly and transparently who should qualify. In February 2003 the Ombudsman published her second report into continuing care, showing that some people were paying for their care when the NHS should have been doing so. There were follow-up reports published in December 2004 and March 2007.

However, for a significant number of people the injustice from problems with continuing care funding has taken time to be resolved. This has meant that in recent years work on continuing care has been a significant part of our workload. However, 2007-08 was a year of significant national developments in continuing care. We are pleased to report that, in general, Primary Care Trusts, Strategic Health Authorities and the Department of Health made significant strides last year to improve the quality of their assessments, complaint handling and retrospective[1] reviews of funding decisions and to remedy any injustice to those who have wrongly been made to pay for their care.

The work undertaken by our Continuing Care Team in setting out principles and expectations appears to have led to a greater consistency and an end to the strategic flaws seen in earlier years. There was also a reduction in delays, which at least in part resulted from our work with the Department of Health. Consequently, continuing care complaints have been a decreasing part of our workload as the role of the Ombudsman in supporting changes partly arising from her previous published reports draws to a close.

In 2007-08 under 10% (70) of the health cases we accepted for investigation were about continuing care, compared with 2006-07 when more than 27% (239) of the health cases we accepted for investigation were about continuing care. Whereas in 2006-07 we fully or partly upheld 85% of the continuing care complaints investigated, in 2007-08 this figure fell to 56%.

In last year's Annual Report we said that, subject to successful resolution of the remaining applications, we intended to publish a final special report on retrospective funding. We have not been in a position to do this because of the continuing delay in finalising many of the complaints, although there has been progress.

In September 2007, on our recommendation, the Department of Health set a deadline of 30 November 2007 for people to make any remaining retrospective claims for continuing care funding. It encouraged Primary Care Trusts and Strategic Health Authorities to publicise this deadline as widely as possible in order to raise awareness among potential claimants. The Department also gave Primary Care Trusts and Strategic Health Authorities a target of 31 March 2008 to complete all retrospective reviews, barring certain exceptional cases.

[1] A retrospective continuing care review is one where all or the majority of the period for which funding is claimed is before 1 April 2004.

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Case Study

Apology acknowledged failings in consent for breast surgery

In December 2004 Mrs M was referred by her GP for a mammogram which showed that she had small tumours in both breasts. A bilateral mastectomy (surgery to completely remove both breasts) was recommended.

In February 2005 Mrs M attended Torbay Hospital where she was provided with information about her condition. Mrs M discussed the issue of scarring with the Breast Care Nurse and emphasised that the position and cosmetic appearance of the resulting scars were both very important considerations for her. Later that month, the Consultant Surgeon who was to perform the operation gave Mrs M a consent form to sign; however, she had yet to decide whether she would proceed with the proposed surgery and did not sign the form immediately.

In March 2005 Mrs M signed the consent form. She was admitted to Torbay Hospital in early April 2005, and underwent a bilateral mastectomy. When the bandages were removed, Mrs M was horrified to discover that, rather than two scars below the breast line, as she had been expecting, she had been left with what appeared to be a single horizontal scar across her chest wall, above her breast line. Mrs M was shocked and extremely distressed by the extent, position and appearance of her scarring and raised her concerns immediately with a member of the South Devon Healthcare NHS Foundation Trust's staff. Mrs M was discharged the next day.

Two days after her discharge, Mrs M complained to the Trust in writing about the appropriateness of the surgery and the consent procedure in relation to the nature and extent of potential scarring. The Chief Executive responded to the complaint in September 2005 and said that the bilateral mastectomy was the correct procedure and that the surgeon had acted appropriately.

Mrs M remained dissatisfied and in October 2005 she complained to the Healthcare Commission, which found that the procedure was appropriate and the scarring within normal range. It did, however, find shortcomings relating to consent and asked the Trust to look at those issues (both in terms of reminders to staff about the importance of ensuring that consent forms are completed fully, and giving patients the opportunity to ask questions when there is a time lag between consent being given and an operation carried out) and to inform Mrs M of resulting changes in policy. The Commission, in two replies (February and March 2006), concluded that despite the shortcomings identified consent had been obtained on a properly informed basis.

In April 2006 Mrs M complained to the Ombudsman. Mrs M made clear that she had pursued her complaint in order to have it acknowledged that the operation she received was not the one for which she gave consent, not to obtain financial compensation.

We found that the bilateral mastectomy was an appropriate procedure for Mrs M and that some parts of the consent process were reasonable. However, we noted that there was no review of the consent at the time of the admission immediately before the operation. We also concluded that, based on the information given to Mrs M pre-operatively, it would have been reasonable for her to expect two separate scars running horizontally across the lower to middle part of her chest. We found that overall there were sufficiently serious shortcomings in the consent process to undermine the validity of the consent.

The investigation found that, having reviewed appropriate evidence and sourced appropriate advice, the Commission's resulting decision that Mrs M's consent was fully informed was unreasonable. It did not properly reflect the evidence assessed or clinical advice received, and this caused Mrs M additional inconvenience and distress.

As a result of our recommendations, the Trust and the Commission agreed to apologise to Mrs M for the shortcomings identified in our report and the injustice she had suffered.

In addition to the action it had taken as a result of the Commission's recommendations, the Trust also agreed to give Mrs M an assurance that lessons had been learnt from her complaint and an explanation of the changes made to prevent such failures being repeated.

When the first of these two deadlines expired on 30 November 2007, there were about 1,500 outstanding cases in the NHS, which the Department of Health told us would be concluded by the target date of 31 March 2008. Many of these cases had been the subject of complaints to us in the past and were sent back to the appropriate NHS body to be re-reviewed with a robust, transparent process and an understandable, evidence-based decision letter. But just two months later the Department told us that it was not, after all, confident that the NHS was on track to complete all reviews by this target date. It said this was due to difficulties Strategic Health Authorities were having in obtaining evidence and to the larger than expected number of cases that some had received.

We were of course disappointed to receive news of further delay. However, we welcomed the actions the Department of Health put in place to put pressure on Strategic Health Authorities, and the deadline was met in most cases. The significant reduction from the 30 November 2007 figure of about 1,500 retrospective continuing care cases in the NHS to just over 100 cases on 31 March 2008 shows progress. Since then there has been an ongoing reduction in the numbers. The Department's Recovery and Support Team has been working with these Strategic Health Authorities to clear this backlog, and has been keeping us informed of progress.

New National Framework

On 26 June 2007 the Department of Health published the *National Framework for NHS Continuing Care and NHS Funded Nursing Care in England* – something that we recommended in our 2004 follow-up report on continuing care. This came into operation on 1 October 2007, and established national criteria for eligibility for continuing care funding and a framework for assessing who should receive it. In essence, it aims to make funding decisions on who is eligible for NHS continuing care *'fairer, faster and easier to understand'*.

It is not retrospective, so does not apply to any claims made before 1 October 2007. However, the set of assessment tools it contains is being used to improve the handling of retrospective claims. Strategic Health Authorities tell us that this Framework is greatly helping them come to speedy and just decisions about those who should receive NHS funding for continuing care.

An improvement in the quality of continuing care complaint handling and reviews

When an individual makes a complaint about a retrospective review of local funding decisions for continuing care, they make that complaint in the first instance to their Primary Care Trust. If they are dissatisfied with the outcome, they take it to their Strategic Health Authority and then, if the matter is still not resolved, to the Ombudsman.

So far, the evidence suggests that the quality of these reviews has improved during the last year. We have been encouraged by the quality of those referred to us. In particular, we are pleased that we have seen far fewer instances of the sort of systemic flaws that we saw in the past. These were characterised, for example, by poor portrayals of healthcare needs, inadequate assessment panels and failure to communicate sufficiently well with family members. We are also pleased to report that we generally have good relations with Strategic Health Authorities, and usually discuss with them in advance the cases we are proposing to send back for their attention, with the result that they have complied with our recommendations in full, as expected.

In last year's Annual Report, we expressed our confidence that claimants would in future receive a robust, fair and transparent review of their eligibility. This confidence was well placed, and we believe that the higher quality of review stems from the fact that we encourage Strategic Health Authorities, in our reports on investigations and other documents, to use our *Principles of Good Administration* when reviewing claims. We have emphasised to them that a thorough, fair and robust review process must include:

- evidence that the person's individual healthcare needs were properly presented;
- a fair, proportionate and reasonable process of assessment/review, which is inclusive of relatives and carers;
- consideration of the person's individual healthcare needs by an appropriately constituted and qualified panel, and comparison of the healthcare needs to the eligibility criteria; and
- a decision conveyed to the claimant that clearly explains how it was reached, the evidence used, and the rationale.

Many Strategic Health Authorities have told us that the *Principles of Good Administration* and the accompanying explanations have helped them develop much better systems for reviews and assessments.

'I thought you would like to know that South Central SHA, via West Berkshire PCT, has at long last paid me the outstanding amount owed as a result of your office upholding my complaint/s against the former Thames Valley SHA and Wokingham PCT... Please pass this on to all those who have helped in this long and frustrating business.'

Mr Z, a complainant featured in our 2003 continuing care report

Working with other Ombudsmen in the UK and beyond

This is the first Annual Report in which we have included a separate chapter on our work with other Ombudsmen. PHSO has always looked for opportunities to work collaboratively with other Ombudsmen in the UK and beyond to ensure fair outcomes for complainants and to share and develop best practice. The recent Regulatory Reform Order and the increasing demands of complex cases and multiple jurisdictions make joint working an area of growing importance. During 2007-08, we worked on joint investigations with two other Ombudsmen schemes: the Local Government Ombudsmen in England and the Public Services Ombudsman for Wales. We accepted eight cases for joint investigation and reported on three.

New powers of collaboration

The Regulatory Reform (Collaboration etc. between Ombudsmen) Order (RRO), which came into force on 1 August 2007, granted new powers to three public sector Ombudsmen which will improve and streamline the way they can work together on complaints that cross the boundaries between their jurisdictions, for example complaints about health and social care.

The UK Parliamentary Ombudsman, the Health Service Ombudsman for England and the Local Government Ombudsmen for England can now share information, carry out joint investigations and issue joint reports.

Before the RRO came into force, if a case spanned their jurisdictions, the Ombudsmen had to conduct parallel investigations and publish separate reports of their findings. One high profile example of this was a complaint made by Mr and Mrs Balchin, reported on by the Parliamentary Ombudsman and the Local Government Ombudsman in October 2005. Mr and Mrs Balchin's complaint was against the Department of Transport and Norfolk County Council in relation to the Council's refusal to purchase Mr and Mrs Balchin's former home in advance of an intended road bypass scheme. Although the investigations reached a positive conclusion (Mr and Mrs Balchin were awarded £200,000 compensation, with the Department and the Council each contributing half), the two investigations had to be conducted separately and the Ombudsmen had to issue separate reports.

Figure 7
Joint investigations conducted during 2007-08

	In hand at 1 April 2007	Accepted in the year	Reported on in the year	In hand at 1 April 2008
Health Service Ombudsman for England and Local Government Ombudsman for England	2	7	1	8
UK Parliamentary Ombudsman and Local Government Ombudsman for England	1	-	-	1
Health Service Ombudsman for England and Public Services Ombudsman for Wales	1	1	1	1
UK Parliamentary Ombudsman and Public Services Ombudsman for Wales	1	-	1	-
Total joint investigations	**5**	**8**	**3**	**10**

Although the number of cases accepted for joint investigation is still low, we expect it to rise steadily in the next few years. There were ten joint investigations in hand at the start of 2008-09 and more cases have been accepted for investigation since then. Working jointly and effectively with other Ombudsmen in the UK where we can do so will provide complainants with a better service. Our own *Principles of Good Administration* include, under 'Being customer focused', the need to respond to customers' needs flexibly including, where appropriate, co-ordinating a response with other service providers.

Injustice in residential care

In March 2008 we published our first joint report with the Local Government Ombudsman for England using the new powers under the RRO: *Injustice in residential care: A joint report by the Local Government Ombudsman and the Health Service Ombudsman for England.* The report detailed the investigations into complaints made to the Local Government Ombudsman and the Health Service Ombudsman against Buckinghamshire County Council and Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust[2] respectively. The complaints were made by Mr and Mrs T about the care provided to their son, Mr U, an adult with severe learning disabilities (see case study 22). Our investigations found that there had been maladministration by both the Council and the Trust, both in the level of care Mr U received and in the way in which Mr and Mrs T's complaints were handled, which resulted in unremedied injustice for Mr U and his parents.

The involvement of both the Trust and Council in the case was a complicating factor from the outset. Although Mr U's parents voiced their concerns to both bodies, there was delay in responding to these concerns, and a great deal of confusion as to which body should address the separate aspects of the complaint. Had the RRO been in force when we first received the complaints from Mr and Mrs T, we could immediately have initiated a joint investigation which might have resulted in a faster resolution of the complaints for Mr and Mrs T and Mr U. Nevertheless, having the statutory power to issue a joint report on our separate investigations was invaluable in ensuring that the Ombudsmen were able to consider maladministration, and any resulting injustice, in the round. This, in turn, allowed them to focus on recommending a remedy in the round, which reflected the injustice experienced by Mr and Mrs T and their son, rather than the constraints imposed by jurisdictional boundaries and different complaint procedures.

Mr U's case provides an example of where human rights concerns were an explicit consideration during the investigation.

[2] During the period covering the events detailed in the report, the predecessor Trust was known as Buckinghamshire Mental Health NHS Trust.

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Case Study

Injustice in residential care

Mr U is an adult with severe learning disabilities who needs one-to-one attention for about 95% of his waking time. In June 2001 Mr U was moved to a residential care home run by the Oxfordshire & Buckinghamshire Mental Health Partnership Trust (the Trust). In July 2002, under an agreement, Buckinghamshire County Council (the Council) undertook to provide services to care home residents on behalf of the Trust. From about February 2002, Mr U's parents (Mr and Mrs T) became concerned about his clinical and social care which they felt was having an adverse effect on his behaviour. They subsequently complained to the Council about a number of matters, including that staff behaved inappropriately towards residents and that once they had found their son unwashed and unshaven with his clothes covered in faeces and urine, and that staff had offered no explanation, apology or help. Whilst at home during the Christmas 2002 break, Mr U suffered from anxiety and refused to leave the house. His parents felt that was because he had a fear of returning to the care home. Mr and Mrs T looked after their son without any external support until March 2003, when he was returned to the Council's care. When his needs were finally assessed, and a Care Plan prepared, Mr U was moved to a different care home which provided the appropriate level of care and support.

The Ombudsmen concluded that Mr U's care needs were never properly assessed while at the original care home, and that there were significant failings in the care he received. The Ombudsmen also concluded that, as a result of the inability of both the Council and the Trust to reach agreement as to their relative responsibilities for Mr U's care and respond appropriately to their concerns, Mr and Mrs T were caused a great deal of anxiety and distress in attempting to care for Mr U for a period at home without any support as they did not feel that he could return to the care home about which they were so concerned. In addition, Mr and Mrs T paid expenses while their son was resident in the care home which should have been paid for from his funding.

As for Mr U's human rights, Article 3 (inhuman or degrading treatment), Article 8 (respect for private and family life and home) and Article 14 (prohibition of discrimination) were relevant, but neither the Council nor the Trust gave them proper or timely consideration. That was maladministrative and contributed to the injustice suffered.

We recommended that the Trust and the Council each make a payment of £16,000, to remedy the acute anxiety and distress Mr U and his parents must have experienced, and the expenses they had unnecessarily incurred.

People in detention and custody

Investigations that arise from complaints by people who are in prison, or held in custody or detention for other reasons, are often among the most complex. There are a number of reasons for this. They are, by definition, a disadvantaged group and often vulnerable, and may be unable to complain through the right channels when they receive unacceptable levels of service. In addition, as currently constituted, the systems for handling complaints from people in custody do not help. In England alone, there are two separate channels for handling complaints relating to health provision in immigration removal centres and prisons: one for healthcare provided by the NHS; and one for healthcare provided privately. Scotland, Wales and Northern Ireland have their own separate channel for health complaints. In addition, there are separate channels for non-health complaints.

Within such a complex and fragmented framework, it is difficult to ensure that people in custody have access to clear and comprehensive information about the avenues of complaint that are available to them. It is therefore essential that Ombudsmen work together to help people navigate the complaints system. The objective must be to secure an independent, comprehensive, coherent and accessible Ombudsman system for all people in custody.

We have had continuing contact with the Department of Health, the National Offender Management Service, the Prisons and Probation Ombudsman and the Healthcare Commission to share learning about prison complaints. In particular, we have provided the Department of Health and the National Offender Management Service with relevant background information to assist them in updating instructions to Prison Service staff on dealing with complaints about healthcare.

We have also liaised with the UK Border Agency about the complaints procedures applying to immigration removal centres – some of which are operated by the Prison Service, while others are privately run on behalf of the Agency. This contact with the Agency has been useful in producing a redraft of their guidance to staff, which will correctly reflect the role of the NHS, the Prisons and Probation Ombudsman and the Parliamentary and Health Service Ombudsman in dealing with complaints about healthcare for people in detention or custody.

The case of Mr W illustrates how joint investigation of a complaint may be the best way to reach a suitable remedy.

Mr W, a prisoner in Swansea Prison, was dissatisfied with the handling of his complaint about his psychiatric care and complained to the Parliamentary Ombudsman and the Public Services Ombudsman for Wales. His complaint was about events spanning the time when the responsibility for commissioning primary healthcare services at Swansea Prison transferred from the Prison Service to the NHS in April 2006. The remit for investigating complaints about the provision of primary healthcare services in prisons before that date falls to the Parliamentary Ombudsman, and after that date to the Public Services Ombudsman for Wales. Using the provisions in their respective statutes, both Ombudsmen agreed that Mr W's complaint was best answered by a joint investigation and a single, joint report.

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Case Study

Delay in psychiatric assessment added to prisoner's concern and distress

Mr W was imprisoned in Swansea Prison in November 2005. He was subsequently assessed by the Prison Service GP who referred him to the Prison Psychiatrist for a psychiatric review which took place on 28 November 2005. During this review, the Prison Psychiatrist recommended that Mr W should be assessed by one of the prison's visiting forensic psychiatrists. There is no evidence that such a referral took place at the time and in 2006 Mr W complained to the Prison Service about the lack of psychiatric provision.

Dissatisfied with the outcome of his complaints, Mr W complained to the Parliamentary Ombudsman and the Public Services Ombudsman for Wales, who agreed to conduct a joint investigation.

The Ombudsmen upheld Mr W's complaint of delay in providing him with a psychiatric appointment. The recommendation of the Prison Psychiatrist in November 2005 was not implemented for some months. The Ombudsmen's view was that it was not for the other healthcare staff at the prison to decide that the psychiatrist's recommendation could be overlooked or deferred and that this was a potentially serious shortcoming. In the absence of any reasonable explanation for the failure to promptly implement the recommendation, the Ombudsmen found maladministration by Prison Service staff.

When Mr W was eventually seen by two separate forensic psychiatrists in July and August 2006 it was decided that there was no need to change the arrangements for providing him with psychiatric oversight. Therefore the maladministration did not result in Mr W being without appropriate treatment whilst he awaited his forensic assessment. However, it did add to the injustice that Mr W felt, in terms of his real concern and distress at the time.

The Ombudsmen recommended that the Prison Service provide Mr W with an apology and an explanation of its actions. They also recommended that the prison's Healthcare Service staff should be reminded of the need to ensure that recommendations made by clinicians are properly considered and acted upon promptly.

The international perspective and human rights

While PHSO is keen to work effectively with other UK Ombudsmen, it is also important to be aware of the wider network of Ombudsmen in other countries. This is especially true of the European Network of Ombudsmen, of which PHSO is a member. The value of these links lies in the fresh perspective they offer and in the sharing of knowledge and best practice.

We continue to develop our Human Rights Strategy and Mr U's case earlier provides an example of where human rights concerns were an explicit consideration during an investigation.

The Ombudsman attended the Sixth Seminar of the National Ombudsmen of EU Member States and Candidate Countries, in Strasbourg in October 2007, which focused on 'Rethinking good administration in the European Union'. The Ombudsman was invited to give a speech on 'Remedies, redress and solutions' and talked about what Ombudsmen have to offer in terms of individual and public benefit. She took the opportunity to launch PHSO's *Principles for Remedy* on the European stage and also supported a joint statement to *'make the European Union (EU) dimension of the work of Ombudsmen better known and to clarify the service they provide to people who complain about matters within the scope of EU law'*.

The need to uphold human rights was a significant element of the statement, and was also the theme of the 10th Round Table of European Ombudsmen and the Council of Europe Commissioner for Human Rights, attended by the Ombudsman in Athens in April 2007. The aim of the Round Table was to seek greater co-operation between Ombudsmen, the Council of Europe Commissioner for Human Rights, Thomas Hammarberg, and national human rights institutions. The initiative was a response to the backlog of 90,000 cases currently facing the European Court of Human Rights in Strasbourg. It was also in recognition of the need to bring human rights 'out of the court room' and into the administrative mainstream. The Ombudsman met Mr Hammarberg on his visit to London in February 2008, when he visited PHSO's office in Millbank and discussed, among other matters, our Human Rights Strategy.

In March 2008 the Ombudsman met Dr Nicola Brewer, Chief Executive of the new Equality and Human Rights Commission, to discuss matters of joint concern, including the co-operation sought by the Council of Europe.

Also in March 2008 the Ombudsman gave the keynote address at a seminar for regulators and inspectors organised by the Human Rights Division of the Ministry of Justice. The aim of the seminar was to assess ways in which human rights principles can be applied in inspection and regulatory frameworks to ensure that public services are not only human rights compliant, but also embrace human rights underlying values.

Our workload and performance: facts and figures

Being accountable for our performance against the plans and targets we have set ourselves is important to us. Overall, we made big strides during the year on a number of our priorities, for example in implementing changes required to improve our services for the future, which dominated the year; and commencing key programmes of work around knowledge management and outreach. However, in others, such as some of our operational service standards and targets, we have not achieved what we set out to deliver. This was due to a range of issues and developments during the year that we have addressed. Lessons learned have been taken on board and steps taken to ensure that we continue to make the service improvements achieved in previous years.

Our 2007-08 Corporate Business Plan identified six key corporate priorities for the year. These were:

- achieving our service standards and improving outcomes for complainants;
- developing and using management information to improve performance;
- getting the most from staff, systems and financial resources;
- managing change;
- capturing, organising and sharing our knowledge; and
- developing our external relations, influence and impact.

Achieving our service standards and improving outcomes for complainants

Enquiries we received

During the year we received 12,532 enquiries against an assumption of 16,000 (Details in figures 8a and 8b). Enquiries to PHSO can be initiated by telephone, email or in writing and our response time is monitored as part of our performance reporting framework. Both our service standards for acknowledging email and written enquiries (100% in 1 day and 2 days respectively) were met.

Of the enquiries received, 6,964 related to complaints against Parliamentary bodies, 4,011 were about Health and 1,557 were about bodies outside our jurisdiction.

The top 5 Parliamentary departments complained about in 2007-08 are detailed in figure 9.

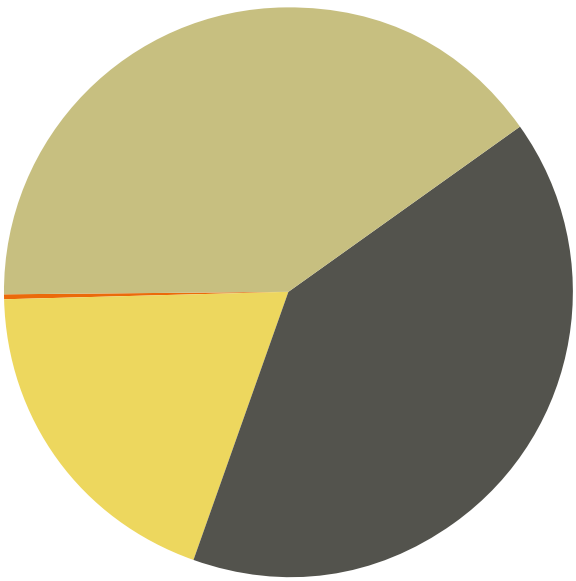
Under the current NHS complaint handling arrangements most health complaints should come to us after they have been considered by the Healthcare Commission – so it is no surprise that over 40% of the 4,011 health related enquiries were about the Commission.

The top ten types of health body and individuals, apart from the Healthcare Commission (1,832), complained about in 2007-08 are detailed in figure 10.

Figure 8a
Enquiries by method of delivery

Number of enquiries received and closed in 2007-08	In hand at 1 April 2007	Net adjustment	Received in the year	Closed*	In hand at 1 April 2008
Telephone	3	1	5,077	4,751	329
Email	20	-2	2,396	2,287	129
Written	644	7	5,048	4,651	1,047
In person	0	0	11	9	2
Total	**667**	**6**	**12,532**	**11,698**	**1,507**

Figure 8b
Received in the year



*Closed including those accepted for investigation

Figure 9
Top 5 Parliamentary bodies complained about in 2007-08

Department for Work and Pensions	Received
Jobcentre Plus	1,063
Child Support Agency	868
The Pension Service	224
Independent Case Examiner	147
Disability and Carers Service	114
Department for Work and Pensions	52
Debt Management Unit	43
Health and Safety Executive	25
Pensions Ombudsman	19
Rent Service	6
Health and Safety Commission	5
Disability Rights Commission	4
Independent Living Funds	3
Remploy Ltd	1
Total	**2,574**

HM Revenue & Customs	Received
HM Revenue & Customs	1,791
The Adjudicator's Office*	512
National Insurance Contributions Office	37
Child Benefit Office	2
Total	**2,342**

Ministry of Justice	Received
HM Courts Service	152
Legal Services Commission	102
Tribunals Service	100
HM Prison Service	53
Information Commissioner	39
Land Registry	34
Ministry of Justice**	25
The Office of the Public Guardian	18
Prisons and Probation Ombudsman	9
Office of Social Security and Child Support Commissioners	4
Official Solicitor	4
Legal Complaints Service	3
The National Archives	2
Advisory Council on National Records and Archives	1
Court Funds Office	1
Immigration Appellate Authority	1
Judicial Appointments and Conduct Ombudsman	1
Total	**549**

*not all complaints about HMRC
**includes 9 against Department for Constitutional Affairs

Figure 9 *continued*
Top 5 Parliamentary bodies complained about in 2007-08

Home Office	Received
Border and Immigration Agency	277
Criminal Records Bureau	40
Home Office	40
UKvisas***	39
Identity and Passport Service	35
Criminal Injuries Compensation Authority	32
Security Industry Authority	27
Criminal Injuries Compensation Appeals Panel	8
Office of the Immigration Services Commissioner	3
Parole Board	2
Central Police Training and Development Authority	1
Correctional Services Accreditation Panel	1
Forensic Science Service	1
National Policing Improvement Agency	1
Total	**507**

Department for Transport	Received
Driver and Vehicle Licensing Agency	194
Driving Standards Agency	23
Highways Agency	20
Department for Transport	17
Vehicle and Operator Service Agency	17
Maritime and Coastguard Agency	6
Total	**277**

Figure 10
Top 10 types of health body complained about in 2007-08

	Received
NHS Hospital, Specialist and Teaching Trusts (Acute)	715
Primary Care Trusts	442
General Practitioners	360
Strategic Health Authorities	314
Foundation Trusts	242
Mental Health, Social Care, Learning Disability NHS Trusts	152
General Dental Practitioners	144
Ambulance Trusts	16
Care Trusts	12
Special Health Authorities	12
Total	**2,409**

*** UKvisas was joint Home Office and Foreign & Commonwealth Office, now Home Office only

How enquiries were closed

In line with the new robust assessment processes introduced in 2006-07, enquiry cases are closed following decisions on whether we can accept the complaint for investigation (that is, if it is within our jurisdiction); and, if we can, whether we should, through assessment of:

- whether the body complained about has had a proper opportunity to resolve it;
- whether there is evidence of maladministration leading to an unremedied injustice; and
- whether there is a reasonable prospect of a worthwhile outcome to an investigation.

In some cases, it may be possible to resolve cases through intervention short of an investigation by working with the relevant parties to the complaint and we will do this wherever possible (see examples of interventions on pages 10 and 34).

During the year, we:

- closed 11,698 enquiries (assumption 16,000);
- closed 3,551 of these after further detailed assessment of whether the complaint should be accepted for investigation (assumption 5,000);
- ended the year with 1,316 enquiries in hand (forecast at or around 750); and
- had a further 191 enquiries in hand which had been referred back to complainants for further information.

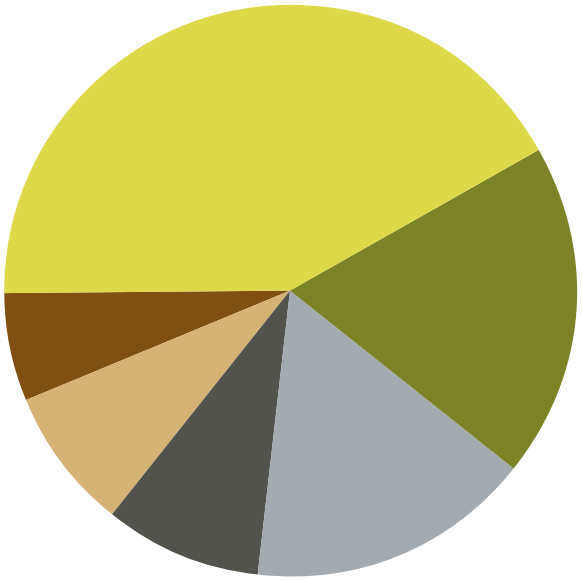
The shortfall in cases closed and increase in cases in hand was partly due to the reduction in enquiries received and partly to other factors, such as productivity and resourcing issues which are now being addressed. As a result of this, only 76% of enquiries were closed within 40 days against our service standard target of 90%.

Figures 11a and 11b show how enquiries were closed during the year.

Figure 11a
Number of types of closed enquiries 2007-08

	Out of remit	Not properly made	Premature	Discretionary	Withdrawn	Accepted for investigation	Total
Enquiry closures	1,813	4,901	2,231	1,080	722	951	11,698
Percentage	16%	42%	19%	9%	6%	8%	100%

Figure 11b
Number of types of closed enquiries 2007-08 (percentage)



42%
Not properly made

19%
Premature

16%
Out of remit

9%
Discretionary

8%
Accepted for investigation

6%
Withdrawn

'Not properly made' are cases which have not been put to PHSO in writing or, on the Parliamentary side, have not been referred by an MP.

Overall, just over three quarters of enquiries were either not properly made, or premature or were about a body that was outside our jurisdiction. That is a cause of concern for us and we have recently implemented a 'Pathway' approach on our website which will make it easier for people to know whether PHSO is the right place for them to bring their complaints, and the right time to do so.

Investigations we carried out

During the year, we:

- accepted 951 cases for investigation (assumption 1,400);
- completed 959 investigations (assumption 1,400);
- ended the year with 618 investigations in hand at 31 March 2008 (forecast aim at or around 620); and
- had 73 cases over 12 months old at 31 March 2008 (target 60).

The shortfalls in investigations accepted and completed were partly due to the full year impact of the more robust processes introduced last year for acceptance of cases for investigation; and partly because of the reduced number of closed enquiries. However, the number of cases remaining in hand at the end of the year was almost the same as in 2006-07 (617).

While we did not achieve the further improvements we wanted to make to reduce further the number of old cases in hand (to 60), we have sustained the significant reduction made last year (from 243 to 73) which had previously been a significant drag on our overall performance. We will maintain a close watch on the number of old cases.

Figure 12
Cases accepted for investigation and concluded in 2007-08 (case level)

	In hand at 1 April 2007	Net adjustment	Accepted for investigation in the year	Discontinued in the year	Reported on	In hand at 1 April 2008
Parliamentary – tax credits	25	1	82	3	54	51
Parliamentary – other	224	3	166	13	236	144
Parliamentary Total	**249**	**4**	**248**	**16**	**290**	**195**
Health – continuing care	70	5	70	3	93	49
Health – other	298	0	633	14	543	374
Health Total	**368**	**5**	**703**	**17**	**636**	**423**
PHSO Total	**617**	**9**	**951**	**33**	**926**	**618**

Figure 13
Top 5 departments by number of complaints accepted for investigation in 2007-08

HM Revenue & Customs	Accepted for investigation
HM Revenue & Customs	91
The Adjudicator's Office*	68
National Insurance Contributions Office	1
Total	**160**

Home Office	Accepted for investigation
Border and Immigration Agency	46
Criminal Injuries Compensation Authority	1
UKvisas**	1
Total	**48**

Department for Work and Pensions	Accepted for investigation
Jobcentre Plus	38
Child Support Agency	18
Independent Case Examiner	9
Debt Management Unit	5
The Pension Service	4
Disability and Carers Service	3
The Pensions Regulator	1
Total	**78**

Ministry of Justice	Accepted for investigation
HM Courts Service	7
Legal Services Commission	6
HM Prison Service	5
Ministry of Justice	1
National Probation Service	1
Official Solicitor	1
Tribunals Service	1
Total	**22**

Department for Environment, Food and Rural Affairs	Accepted for investigation
Department for Environment, Food and Rural Affairs	4
Rural Payments Agency	2
Consumer Council for Water	1
Environment Agency	1
Total	**8**

*not all complaints about HMRC
**UKvisas was joint Home Office and Foreign & Commonwealth Office, now Home Office only

Figure 14
Health complaints accepted for investigation by type of body in 2007-08

	Accepted for investigation
Healthcare Commission	624
Strategic Health Authorities	70
NHS Hospital, Specialist and Teaching Trusts (Acute)	13
Primary Care Trusts	12
Foundation Trusts	8
Mental Health, Social Care, Learning Disability NHS Trusts	5
General Practitioners	5

Figure 15
Top 5 departments by number of complaints reported on

Department for Work and Pensions	Reported on	Fully upheld	Partly upheld	Not upheld
Jobcentre Plus	52	29%	38%	33%
Child Support Agency	28	54%	36%	11%
The Pension Service	13	31%	38%	31%
Debt Management Unit	8	13%	75%	13%
Independent Case Examiner	7	14%	0%	86%
Disability and Carers Service	6	33%	33%	33%
Department for Work and Pensions	2	50%	0%	50%
Health and Safety Executive	2	50%	50%	0%
Total	**118**	**34%**	**37%**	**29%**

HM Revenue & Customs	Reported on	Fully upheld	Partly upheld	Not upheld
HM Revenue & Customs	66	41%	27%	32%
The Adjudicator's Office*	26	15%	8%	77%
National Insurance Contributions Office	1	0%	0%	100%
Total	**93**	**33%**	**22%**	**45%**

Home Office	Reported on	Fully upheld	Partly upheld	Not upheld
Border and Immigration Agency	52	52%	33%	15%
Criminal Records Bureau	6	17%	67%	17%
UKvisas**	3	67%	0%	33%
Security Industry Authority	2	50%	50%	0%
Criminal Injuries Compensation Appeals Panel	1	0%	100%	0%
Criminal Injuries Compensation Authority	1	0%	100%	0%
Home Office	1	0%	100%	0%
Identity and Passport Service	1	0%	0%	100%
Total	**67**	**46%**	**37%**	**16%**

*not all complaints about HMRC
**UKvisas was joint Home Office and Foreign & Commonwealth Office, now Home Office only

Ministry of Justice	**Reported on**	**Fully upheld**	**Partly upheld**	**Not upheld**
HM Courts Service	17	47%	18%	35%
HM Prison Service	3	0%	67%	33%
Legal Services Commission	3	33%	33%	33%
Information Commissioner	1	0%	100%	0%
Land Registry	1	0%	0%	100%
Ministry of Justice	1	0%	100%	0%
Tribunals Service	1	0%	0%	100%
Total	**27**	**33%**	**30%**	**37%**

Department for Environment, Food and Rural Affairs	**Reported on**	**Fully upheld**	**Partly upheld**	**Not upheld**
Department for Environment, Food and Rural Affairs	6	17%	33%	50%
Rural Payments Agency	3	67%	33%	0%
Environment Agency	2	0%	0%	100%
Consumer Council for Water	1	0%	0%	100%
Total	**12**	**25%**	**25%**	**50%**

Figure 16
Health investigations reported on by type of body

	Reported on	Fully upheld	Partly upheld	Not upheld
Healthcare Commission	508	35%	10%	55%
Strategic Health Authorities	93	52%	4%	44%
General Practitioners	21	24%	29%	48%
NHS Hospital, Specialist and Teaching Trusts (Acute)	21	43%	24%	33%
Primary Care Trusts	19	37%	32%	32%
Foundation Trusts	18	50%	17%	33%
Mental Health, Social Care, Learning Disability NHS Trusts	4	25%	25%	50%
General Dental Practitioners	2	100%	0%	0%
Ambulance Trusts	1	100%	0%	0%
Total	**687**	**38%**	**11%**	**51%**

On our customer service standard for investigations:

- overall, we improved completion of cases within six months from 43% in 2006-07 to 45% but remained short of our target of 55%, reflecting the increasing complexity of cases taken on for investigation; and
- we also improved overall performance against our standard for completion at 12 months from 79% to 87%, exceeding our target of 85%.

Figure 17
Performance against service standards for Parliamentary and Health

Completion time from acceptance for investigation to report	Target	Health	Parliamentary	Total
Within 6 months	55%	53%	29%	**45%**
Within 12 months	85%	92%	75%	**87%**

Outcomes of our investigations

Overall, during the year we fully upheld 37% of complaints investigated (34% in 2006-07); partly upheld 18% (28%); and did not uphold the remaining 45% (38%). The picture is quite different for Parliamentary and Health investigations as figure 18 indicates. We upheld the complaint in full or in part in 68% of Parliamentary investigations. In Health investigations we upheld the complaint in full or in part in 49% of cases.

Compliance with recommendations

Over 99% of 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 Parliamentary investigations were for financial compensation for inconvenience or distress, underlining an apology. Others included financial compensation for loss, or some action to remedy the failure identified.

The majority of recommendations in our Health investigations focused on an apology or reconsideration of the decision. Others included action to remedy the failure identified, or some action to prevent a recurrence (for example, a review of or changes to procedures, or staff training). Financial remedies have also featured, for example as compensation for direct financial loss or in recognition of the distress and inconvenience caused by poor complaint handling.

We have experienced particular difficulties with two individual primary care practitioners – one locum GP and one dentist – who were reluctant to comply with our recommendations for financial compensation for poor treatment and/or poor complaint handling. We will not hesitate to 'name and shame' the NHS practitioners in our published reports in such cases and, where we have concerns that their actions or omissions constitute a risk to the health and safety of patients, we will bring our concerns to the attention of the relevant professional regulator and/or to their employer.

Figure 18
Outcome of complaints investigated in 2007-08

	Reported on: fully upheld	Reported on: partly upheld	Reported on: not upheld
Parliamentary – tax credits	40%	20%	40%
Parliamentary – other	35%	34%	31%
Parliamentary Total	**37%**	**31%**	**32%**
Health – continuing care	51%	5%	44%
Health – other	36%	12%	53%
Health Total	**38%**	**11%**	**51%**
PHSO Total	**37%**	**18%**	**45%**

Figure 19: Parliamentary complaints by body complained about in 2007-08

	In hand at 1 April 2007	Net adjustment	Accepted for investigation in the year	Discontinued in the year	Reported on	Reported on: fully upheld	Reported on: partly upheld	Reported on: not upheld	In hand at 1 April 2008
Charity Commission	1	0	0	0	0	0%	0%	0%	1
Department for Business, Enterprise and Regulatory Reform – Coal Authority	1	0	0	0	0	0%	0%	0%	1
Department for Business, Enterprise and Regulatory Reform – Yorkshire Forward	1	0	0	0	1	0%	0%	100%	0
Department for Business, Enterprise and Regulatory Reform (formerly Department of Trade and Industry)	1	0	0	0	1	0%	0%	100%	0
Department for Children, Schools and Families – Children and Family Court Advisory and Support Service	1	0	0	0	1	100%	0%	0%	0
Department for Communities and Local Government	2	0	0	0	2	100%	0%	0%	0
Department for Communities and Local Government – Planning Inspectorate	0	0	1	0	1	0%	100%	0%	0
Department for Communities and Local Government – Standards Board for England	2	0	0	0	2	0%	50%	50%	0
Department for Culture, Media and Sport – Big Lottery Fund	0	0	1	0	1	100%	0%	0%	0
Department for Culture, Media and Sport – English Heritage	1	0	0	0	1	0%	0%	100%	0
Department for Culture, Media and Sport – Sport England	2	0	0	0	2	100%	0%	0%	0

Department for Environment, Food and Rural Affairs	5	0	4	0	6	17%	33%	50%	3
Department for Environment, Food and Rural Affairs – Consumer Council for Water	0	0	1	0	1	0%	0%	100%	0
Department for Environment, Food and Rural Affairs – Environment Agency	3	0	1	0	2	0%	0%	100%	2
Department for Environment, Food and Rural Affairs – Rural Payments Agency	5	0	2	0	3	67%	33%	0%	4
Department for Innovation, Universities and Skills – Learning and Skills Council for England	0	0	1	0	1	100%	0%	0%	0
Department for Innovation, Universities and Skills – National Endowment for Science, Technology and the Arts	1	0	0	0	1	0%	0%	100%	0
Department for Transport – Driver and Vehicle Licensing Agency	0	0	3	0	0	0%	0%	0%	3
Department for Transport – Highways Agency	2	1	0	0	2	50%	50%	0%	1
Department for Work and Pensions – Debt Management Unit	7	2	5	0	8	13%	75%	13%	6
Department for Work and Pensions	3	-1	0	0	2	50%	0%	50%	0
Department for Work and Pensions – Child Support Agency	31	0	18	0	28	54%	36%	11%	21
Department for Work and Pensions – Disability and Carers Service	7	0	3	1	6	33%	33%	33%	3

Figure 19 *continued:* Parliamentary complaints by body complained about in 2007-08

	In hand at 1 April 2007	Net adjustment	Accepted for investigation in the year	Discontinued in the year	Reported on	Reported on: fully upheld	Reported on: partly upheld	Reported on: not upheld	In hand at 1 April 2008
Department for Work and Pensions – Health and Safety Executive	2	0	0	0	2	50%	50%	0%	0
Department for Work and Pensions – Independent Case Examiner	8	0	9	0	7	14%	0%	86%	10
Department for Work and Pensions – Jobcentre Plus	50	5	38	2	52	29%	38%	33%	39
Department for Work and Pensions – The Pension Service	12	1	4	0	13	31%	38%	31%	4
Department for Work and Pensions – Pensions Regulator	0	0	1	0	0	0%	0%	0%	1
Department of Health	0	0	2	0	2	50%	0%	50%	0
Department of Health – Commission for Social Care Inspection	1	0	1	0	2	0%	100%	0%	0
Department of Health – General Social Care Council	1	0	0	0	1	0%	0%	100%	0
Department of Health – Healthcare Commission	0	0	1	0	1	0%	0%	100%	0
Foreign & Commonwealth Office	5	0	0	0	5	60%	20%	20%	0
HM Revenue & Customs	40	3	91	5	66	41%	27%	32%	63

HM Revenue & Customs – Child Benefit Office	2	0	0	0	0	0%	0%	0%	2
HM Revenue & Customs – National Insurance Contributions Office	2	1	1	0	1	0%	0%	100%	3
HM Revenue & Customs – The Adjudicator's Office	0	7	68	2	26	15%	8%	77%	47
HM Treasury	2	0	0	0	0	0%	0%	0%	2
HM Treasury – Valuation Office Agency	1	0	0	0	0	0%	0%	0%	1
Home Office	1	1	0	0	1	0%	100%	0%	1
Home Office – Border and Immigration Agency	33	0	46	8	52	52%	33%	15%	19
Home Office – Criminal Injuries Compensation Appeals Panel	1	0	0	0	1	0%	100%	0%	0
Home Office – Criminal Injuries Compensation Authority	1	0	1	0	1	0%	100%	0%	1
Home Office – Criminal Records Bureau	6	0	0	0	6	17%	67%	17%	0
Home Office – Identity and Passport Service	1	0	0	0	1	0%	0%	100%	0
Home Office – Security Industry Authority	2	0	0	0	2	50%	50%	0%	0

Figure 19 *continued:* Parliamentary complaints by body complained about in 2007-08

	In hand at 1 April 2007	Net adjustment	Accepted for investigation in the year	Discontinued in the year	Reported on	Reported on: fully upheld	Reported on: partly upheld	Reported on: not upheld	In hand at 1 April 2008
Home Office – UKvisas	2	1	1	1	3	67%	0%	33%	0
Ministry of Defence – Service Personnel and Veterans Agency	1	0	2	0	1	0%	100%	0%	2
Ministry of Justice – HM Courts Service	16	0	7	1	17	47%	18%	35%	5
Ministry of Justice – HM Prison Service	3	3	5	0	3	0%	67%	33%	8
Ministry of Justice – Information Commissioner	1	0	0	0	1	0%	100%	0%	0
Ministry of Justice – Land Registry	1	0	0	0	1	0%	0%	100%	0
Ministry of Justice – Legal Services Commission	4	0	6	0	3	33%	33%	33%	7
Ministry of Justice – National Probation Service*	1	0	1	0	0	0%	0%	0%	2
Ministry of Justice – Official Solicitor	0	0	1	0	0	0%	0%	0%	1
Ministry of Justice – Tribunals Service	2	0	1	1	1	0%	0%	100%	1
Ministry of Justice**	1	1	1	0	1	0%	100%	0%	2

Northern Ireland Court Service	0	0	1	0	0	0%	0%	0%	1
Office of Fair Trading	0	0	1	0	1	0%	0%	100%	0
Office of the Director General of Water Services (OFWAT)	0	0	1	0	0	0%	0%	0%	1
Total	**279**	**25**	**331**	**21**	**346**	**36%**	**31%**	**33%**	**268**

*National Probation Service refers to complaints made under the Victim's Code
**Includes Department for Constitutional Affairs.

Figure 20: Distribution of continuing care health cases by Strategic Health Authority area 2007-08 (case level)

Strategic Health Authorities – continuing care	In hand at 1 April 2007	Net adjustment	Accepted for investigation in the year	Discontinued in the year	Reported on	Reported on: fully upheld	Reported on: partly upheld	Reported on: not upheld	In hand at 1 April 2008
East Midlands Strategic Health Authority	7	0	3	0	9	44%	11%	44%	1
East of England Strategic Health Authority	13	2	3	0	16	63%	6%	31%	2
London Strategic Health Authority	2	0	10	1	4	50%	0%	50%	7
North East Strategic Health Authority	0	0	3	0	2	50%	0%	50%	1
North West Strategic Health Authority	20	0	15	1	21	48%	5%	48%	13
South Central Strategic Health Authority	8	0	8	0	11	55%	0%	45%	5
South East Coast Strategic Health Authority	7	1	8	0	11	36%	0%	64%	5
South West Strategic Health Authority	6	2	6	1	7	86%	14%	0%	6
West Midlands Strategic Health Authority	4	0	4	0	5	20%	0%	80%	3
Yorkshire and the Humber Strategic Health Authority	3	0	10	0	7	43%	14%	43%	6
Total	**70**	**5**	**70**	**3**	**93**	**51%**	**5%**	**44%**	**49**

Strategic Health Authorities – non-continuing care	In hand at 1 April 2007	Net adjustment	Accepted for investigation in the year	Discontinued in the year	Reported on	Reported on: fully upheld	Reported on: partly upheld	Reported on: not upheld	In hand at 1 April 2008
East Midlands Strategic Health Authority	3	1	0	1	1	0%	100%	0%	2
East of England Strategic Health Authority	5	-1	0	0	4	75%	25%	0%	0
London Strategic Health Authority	10	-1	3	2	6	0%	33%	67%	4
North East Strategic Health Authority	3	0	0	0	0	0%	0%	0%	3
North West Strategic Health Authority	8	0	2	0	8	63%	25%	13%	2
South Central Strategic Health Authority	8	0	0	0	5	60%	20%	20%	3
South East Coast Strategic Health Authority	4	-1	2	1	3	33%	33%	33%	1
South West Strategic Health Authority	4	-2	2	0	3	0%	67%	33%	1
West Midlands Strategic Health Authority	1	1	0	0	2	50%	50%	0%	0
Yorkshire and the Humber Strategic Health Authority	1	0	1	0	2	0%	50%	50%	0
Healthcare Commission	251	3	623	10	509	33%	13%	55%	358
Total	**298**	**0**	**633**	**14**	**543**	**33%**	**14%**	**53%**	**374**

Figure 21: Distribution of non-continuing care health cases by Strategic Health Authority area 2007-08 (case level)

Figure 22: Distribution of health cases by Strategic Health Authority area 2007-08 (case level)

Strategic Health Authorities	In hand at 1 April 2007	Net adjustment	Accepted for investigation in the year	Discontinued in the year	Reported on	Reported on: fully upheld	Reported on: partly upheld	Reported on: not upheld	In hand at 1 April 2008
East Midlands Strategic Health Authority	10	1	3	1	10	40%	20%	40%	3
East of England Strategic Health Authority	18	1	3	0	20	65%	10%	25%	2
London Strategic Health Authority	12	-1	13	3	10	20%	20%	60%	11
North East Strategic Health Authority	3	0	3	0	2	50%	0%	50%	4
North West Strategic Health Authority	28	0	17	1	29	52%	10%	38%	15
South Central Strategic Health Authority	16	0	8	0	16	56%	6%	38%	8
South East Coast Strategic Health Authority	11	0	10	1	14	36%	7%	57%	6
South West Strategic Health Authority	10	0	8	1	10	60%	30%	10%	7
West Midlands Strategic Health Authority	5	1	4	0	7	29%	14%	57%	3
Yorkshire and the Humber Strategic Health Authority	4	0	11	0	9	33%	22%	44%	6
Healthcare Commission	251	3	623	10	509	33%	13%	55%	358
Total	**368**	**5**	**703**	**17**	**636**	**36%**	**13%**	**52%**	**423**

Requests to us for information

During the year we received 207 requests for information under the Freedom of Information Act and Data Protection Act (over 250 were received in 2006-07). We reported last year that due to the volume of requests and specific difficulties with responding to many of these (due to the special legislative position of the Ombudsman), we did not always meet the statutory timescales for responding to requests. In 2007-08 we addressed this issue and significantly reduced both the volume of cases in hand to 13 and the time taken to reply.

Figure 23
Information requests resolved

Within relevant time limit	135 (52%)
Outside relevant time limit	127 (48%)

Complaints about us

As a measure of the performance of our own service, over the year we:

- received 773 complaints about us (significantly down from 1,219 in 2006-07);
- resolved 964; and
- ended the year with 99 in hand (296 in 2006-07), exceeding our target of having no more than 120 in hand at the year end.

Since 1 January 2008 all complaints about us have been handled within a new 'single-tier' system, our service standard for which is to provide a substantive response on 90% of these within 16 weeks. During the year we achieved 58%, which we will be seeking to improve on over the first full year of the new system.

Of the complaints we received about us:

- 431 were about our handling of enquiries;
- 137 were about health investigations;
- 190 were about parliamentary investigations; and
- 15 were about the Freedom of Information Act and the Data Protection Act.

Of these:

107 were fully or partly upheld, a significant improvement over the 157 in 2006-07, within which:

- errors upheld about our decisions were down from 34 to 22;
- errors partly upheld were down from 69 to 32; and
- service complaints were reduced from 54 to 53.

Judicial reviews of our decisions and actions

There were ten applications for judicial review of our decisions and two county court claims in the year.

Of the ten judicial reviews, nine were refused permission to proceed (although one of these is now the subject of an appeal and another a renewal application). The other judicial review was granted permission to proceed but was dismissed by the court.

One of the county court claims was dismissed by the court; the other was withdrawn by the claimant.

Casework quality

Several steps were taken in the year to improve the quality of our casework, which will be continuing in 2008-09.

In October 2007 we introduced a new Delegation Scheme and Accountability Framework related to exercising decisions on casework; and a new Outcomes and Learning Directorate was set up to ensure that the lessons from our work are captured and used appropriately internally and externally. We have also undertaken assurance work to ensure that we apply our *Principles of Good Administration* and *Principles for Remedy* in practice in our casework and in our service to customers.

Progress on quality can be seen in the reduced number of upheld complaints about our decisions.

Joint investigations with the Local Government Ombudsmen

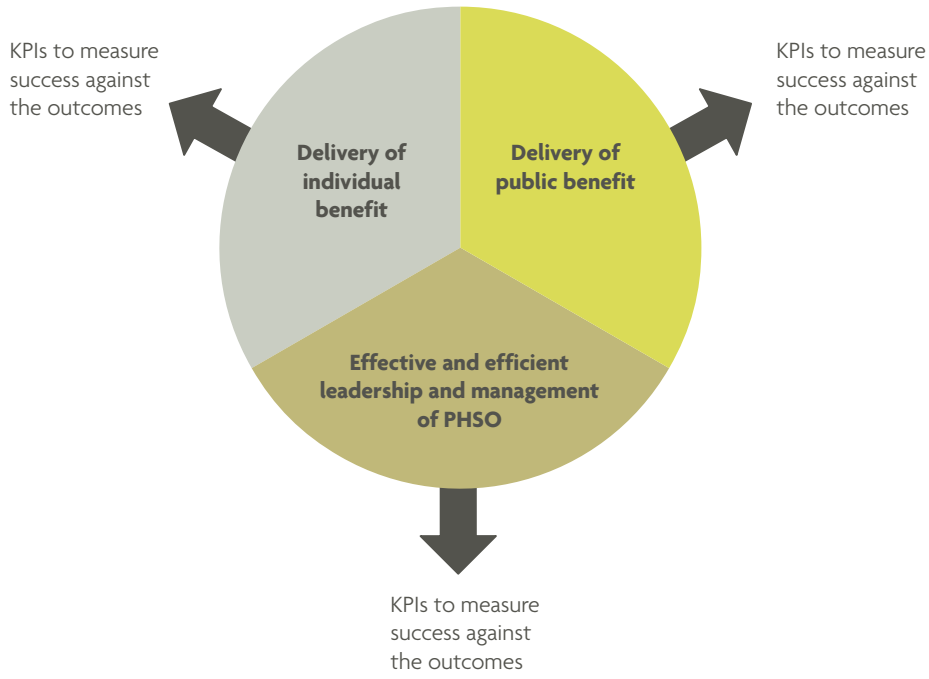
We have developed our approach to working with the Local Government Ombudsmen for England following enactment of the RRO enabling joint investigations to be carried out. We ensured that all key stakeholders were notified of the RRO provisions, and in March 2008 we published our first joint report, *Injustice in residential care*. Several further joint investigations are in train and will be reported on in 2008-09.

Developing and using management information to improve performance

Improving our corporate performance framework

This year we developed and implemented an improved corporate performance framework, which is based on an adapted balanced scorecard and which reflects our strategic and business plans. Our framework includes Key Performance Indicators (KPIs) to measure, monitor and review long-term performance against our strategic objectives; performance against our annual internal targets and service standards; and the effectiveness of our performance in managing our business. This is shown in the following diagram.

Figure 24
PHSO's balanced scorecard



Our KPIs can be found in our 2008-11 Strategic Plan. Our internal targets and service standards can be found in our 2008-09 Corporate Business Plan. Both plans are available from PHSO's website at www.ombudsman.org.uk

A key element of our performance management system is an effective research plan designed to populate our KPIs with information from our internal systems and from external sources. This was designed during the year and has been implemented.

Improving our case management and data quality

Significant steps were taken during the year to improve the quality of our data through enhancement of our case management system, replacement of our human resources system and regular audits of data produced.

Applying our Principles to our own work

- Getting it right: reducing the numbers of complaints about us; ensuring we are complying with legislation applicable to us; effective auditing of our policies and procedures.
- Being customer focused: publishing our reports in a variety of formats to improve accessibility; establishing and publishing customer service standards; using feedback from our surveys and from complaints about us to help us improve our service.
- Being open and accountable: maintaining clear audit trails for our decisions; publishing our policies and procedures; demonstrating accountability through reporting openly on our performance.
- Acting fairly and proportionately: making evidence-based decisions taking account of materiality and risk; putting in place internal processes which ensure that our decisions and remedies recommended are consistent and fair.
- Putting things right: improving our complaints procedures and processes to make them easier and clearer for customers to navigate and use.
- Seeking continuous improvement: reviewing the effectiveness of changes we have made to our structures and processes; acting on lessons learned from this and our performance; investing in new ways of working and our infrastructure to support better delivery.

Getting the most from staff, systems and financial resources

Applying our *Principles of Good Administration* to our own work

Ensuring that we live up to our own principles of what makes for good administration is of fundamental importance to us, both internally and in the way we carry out our casework. We maintain a constant focus on improving how we do our work and putting in place improvements where necessary in the service we provide.

Investing in our people and taking forward our Equality and Diversity Strategy

PHSO successfully achieved Investors in People re-accreditation in 2007-08 and we directly invested nearly £400,000 in the learning and development of our staff over the year, supported by a dedicated team. Particular emphasis this year was on management training with a Management Development Programme and an Aspiring to Management Programme being introduced. Substantial effort was also put into improving the effectiveness of our performance management systems. We will be building further on this in 2008-09.

We have continued to implement our Equality and Diversity Strategy with relevant awareness training. A Workforce Diversity Action Plan was agreed including targets of increasing the number of black and minority ethnic staff working for PHSO to better reflect the profile of potential complainants. Performance against this is being regularly monitored.

Managing our resources effectively

Our summary financial results are included in this report. Performance against the financial targets in our 2007-08 Corporate Business Plan was as follows:

- our net resource underspend of £174,000 was within our target limit for underspending of less than £500,000;
- our capital underspend of £199,000 was outside our target limit for underspending of £100,000 due to a decision to defer replacement of IT hardware;
- we recovered 100% of income due in the year, although excess income recovered was £53,000 above the £40,000 target we set due to factors outside our control;
- we remained within the Net Cash Requirement sanctioned by Parliament;
- we paid 99.2% (2006-07: 99.6%) of supplier invoices within our target of 30 days;
- our resource budgets were managed to within 1% of tolerances set, within our target of limiting variance to no more than 2%; but capital budgets were outside the 5% tolerance at 12.9% due to the deferment of IT spending mentioned above; and
- our depreciation charges for the year of £1,298,000 were within our target of being no more than £200,000 more than our capital investment of £1,360,000 (actual variance – £62,000) which evidences the maintenance of our capital base.

Over the year our staffing numbers reduced by 21.6, and full-year turnover was very high at 25%, which had an impact on our performance. This was due mainly to the effects of our restructuring programme. A substantial amount of resource was invested in 31 recruitment exercises aimed primarily at strengthening our casework, management and corporate capability. 48 of the 52 positions advertised were filled successfully at the first attempt, with 3 of the other 4 being filled subsequently.

Average sick absence in 2007-08 for PHSO employees was 5.9 days per full-time equivalent (fte), which was well within our target of being no more than 7 days per fte. This was also significantly lower than the public sector average and on a par with the private sector.

Managing change

Reorganising the way we do things

Over the course of this year we implemented a fundamental organisational restructuring under a programme called Organising for the Future, the key aim of which was to strengthen our capacity to deliver on our strategic objectives.

The new structures were successfully implemented by November 2007. This included a new Customer Services and Assessment Directorate to improve our front-end processes for handling customer enquiries and assessing whether complaints should be investigated. It also included setting up an Outcomes and Learning Directorate to ensure that the lessons from our casework are captured and disseminated, and to provide enhanced capacity to develop effective casework guidance, supporting improvements in the quality of our work and caseworker skills. The embedding of the new structures and the new ways of working has been supported with development awaydays and team events. Performance has been affected by a high number of caseworker vacancies, an issue which is being addressed.

Corporately, we put in place a new Division to manage our Policy Information and Communications. This includes four teams covering external liaison and outreach; policy and research; internal and external communications; and knowledge and information management. These functions are recognised as essential to the future development and effectiveness of PHSO, and continuing to strengthen their capability will be a priority in 2008-09.

Capturing, organising and sharing our knowledge

Managing our knowledge and information better

Getting the most from the extensive knowledge and information held both by the organisation and our staff is essential to improving the effectiveness of PHSO. In 2007-08 we launched and communicated internally and externally our programme to manage the improvements we recognise are required in this area. A new and experienced senior manager was appointed in February 2008 as Head of Knowledge and Information Management to lead the programme, and a practical plan and associated governance for delivery of the programme were developed.

This includes five interconnected workstreams covering people; information content; culture; processes; and technology. During the year key activities included completing a joint review with The National Archives of our records management arrangements, which provides a clear plan to ensure that these reflect best practice as well as expectations in accordance with our own *Principles of Good Administration*. We also developed and implemented a new corporate business classification (taxonomy) for our casework management system to support our casework related reporting ability.

Developing our external relations, influence and impact

Applying *Principles of Good Administration* and *Principles for Remedy* in our casework

Our *Principles of Good Administration* were published in March 2007 and our *Principles for Remedy* in October 2007 and we have applied them increasingly in our casework throughout 2007-08. Our casework conference for staff in 2008 focused specifically on sharing good practice in applying both sets of Principles in our casework.

Strengthening our outreach

In light of customer and stakeholder feedback we have recognised the need to strengthen how we approach and execute more effective relationships with the bodies we deal with. We therefore developed and agreed an external relations strategy and established a new team, External Liaison and Outreach, to deliver it. This year the team has been focusing on setting out guidance to communicate better to our stakeholders the approach we take in considering complaints and the expectations we have of bodies within jurisdiction. A key product from this will be a new document, the third in the Ombudsman's trilogy of principles – the *Principles of Good Complaint Handling* – which is being consulted on and will be launched in autumn 2008.

Working towards new NHS complaint handling arrangements

Throughout 2007-08 we worked closely in support of the Department of Health's intention to introduce revised complaint handling arrangements for health and social care. This included responding positively to their consultation document, *Making Experiences Count*, which was heavily influenced by criticisms we have made of the current system in our report, *Making things better? A report on reform of the NHS complaints procedure in England*, published in March 2005. We strongly supported the Department of Health's proposals for abolishing the second stage complaint handling role currently carried out by the Healthcare Commission and the introduction of new arrangements for a simpler process, with the emphasis on NHS bodies dealing more effectively with complaints made to them.

In the latter part of 2007-08 we commenced planning for the changes needed in PHSO to deal with implementation of the new arrangements which will take effect from 1 April 2009. This will significantly increase the workload of PHSO and substantial resources will be invested in 2008-09 to ensure that we are ready to take this on.

Reporting on our casework and learning

The following reports to Parliament were published in 2007-08:

- *Tax Credits: Getting it wrong?* – October 2007
- *The introduction of the ban on swill feeding* – December 2007
- *Injustice in residential care* – March 2008.

As a result of the creation of our new Outcomes and Learning Directorate in 2007-08 we are now much better placed to publish regular summaries of cases and the first of these, *Remedy in the NHS*, was published in June 2008.

The investigation into the prudential regulation of Equitable Life also continued during 2007-08 and the report of that investigation has now been published, in July 2008.

Managing our resources

The Parliamentary and Health Service Ombudsman's full *Resource Accounts 2007-08* will be laid before Parliament on 6 October 2008 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 2008

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 2007-08, which were signed by the Ombudsman on 17 September 2008. While the summary below does not contain sufficient detail to allow for 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 Resource Accounts.

Ann Abraham
17 September 2008
Parliamentary and Health Service Ombudsman

Statement of the Comptroller and Auditor General to the Houses 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 2008 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 these 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 2008.

T J Burr
Comptroller and Auditor General

Financial review

PHSO's net operating cost for 2007-08 was £24,345,000, comprising expenditure of £24,785,000 spent in carrying out its activities offset by operating income of £440,000. Excluding £93,000 of income that must be surrendered to the Exchequer and £186,000 funding from the Consolidated Fund for the salary and on-costs of the Ombudsman, PHSO's net total resource requirement for the year was £24,252,000, which was an underspend of £174,000 (0.7%) of PHSO's 2007-08 funding as approved by Parliament. This underspend was within our internal targets of not exceeding our total net resource expenditure sanctioned by Parliament and limiting any underspend to less than £500,000.

Capital investment expenditure for the year was £1,338,000, mainly utilised on completing our accommodation refurbishment project. Our net underspend of £199,000 met our target of not exceeding our total capital investment sanctioned by Parliament (£1,537,000). However, it exceeded our internal target of limiting any underspend to less than £100,000. This was due to a decision to defer replacement of IT hardware.

PHSO's reserves have increased by £21,000, which mainly reflects the increase in the gross value of the asset base as a result of the capitalisation of the costs of our accommodation refurbishment project, net of related depreciation.

Summary of resource outturn 2007-08

	2007-08						2006-07	
	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	24,773	347	24,426	24,599	347	24,252	174	22,679
Total resources	**24,773**	**347**	**24,426**	**24,599**	**347**	**24,252**	**174**	**22,679**
Non-operating cost A in A	-	-	-	-	-	-	-	-

PHSO's net cash requirement for the year of £23,956,000 was within our cash financing limit of £24,941,000 as approved by Parliament.

Operating cost statement for the year ended 31 March 2008

	2007-08 £000	2006-07 £000
Administration costs:		
Staff costs	12,777	13,458
Other administration costs	12,008	9,764
Gross administration costs	**24,785**	**23,222**
Operating income	(440)	(369)
Net administration costs	**24,345**	**22,853**
Net operating cost	**24,345**	**22,853**
Net resource outturn	**24,252**	**22,679**

Balance sheet as at 31 March 2008

	31 March 2008		31 March 2007	
	£000	£000	£000	£000
Fixed assets:				
Tangible assets	6,443		6,354	
Intangible assets	519		638	
		6,962		6,992
Current assets:				
Debtors	1,300		968	
Cash at bank and in hand	122		391	
	1,422		1,359	
Creditors (amounts falling due within one year)	(1,445)		(1,597)	
Net current liabilities		(23)		(238)
Total assets less current liabilities		6,939		6,754
Creditors (amounts falling due after more than one year)	(688)		(825)	
Provisions for liabilities and charges	(1,145)		(844)	
		(1,833)		(1,669)
		5,106		**5,085**
Taxpayers' equity				
General fund		4,660		4,709
Revaluation reserve		446		376
		5,106		**5,085**

Cash flow statement for the year ended 31 March 2008

	2007-08	2006-07
	£000	£000
Net cash outflow from operating activities	(22,679)	(22,110)
Capital expenditure and financial investment	(1,461)	(4,958)
Payments of amounts due to the consolidated fund	(5)	(68)
Financing	23,876	27,349
Increase/(decrease) in cash in the period	**(269)**	**213**

The Board as at March 2008

Ann Abraham
Parliamentary and Health Service Ombudsman

Trish Longdon
Deputy Ombudsman

Bill Richardson
Deputy Chief Executive

Philip Aylett
Director of Policy Information and Communications

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

Andrew Puddephatt OBE
Audit Committee Chair

Paula Carter
Advisory Board Member

Tony Redmond
External Board Member

Cecilia Wells OBE
External Board Member

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.[3] The Ombudsman is solely responsible and accountable for the conduct and administration of all work carried out by the Office of the Parliamentary and Health Service Ombudsman and for the decisions made in each case.

The Advisory Board

To enhance the governance of PHSO, improve the transparency with which it operates and bolster the independence of the role, the Ombudsman appointed a non-statutory Advisory Board in 2004. This comprises the Ombudsman herself (as Chair and Chief Executive in line with her statutory accountability) and four non-executive members who bring an external perspective to the Office's work. With the exception of the Chairman of the Commission for Local Administration in England, who joined the Board at the Ombudsman's invitation, all the Advisory Board members were appointed through a process of fair and open competition.

The role of the Advisory Board is to act as a 'critical friend', providing support and advice to the Ombudsman in her leadership of PHSO, and to bring an external perspective to assist her in the development of policy and practice. The Board provides specific advice and support on:

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

The Advisory Board has no role in casework processes or decisions.

The Advisory Board has two formal sub-committees which have key roles in supporting the effective governance of PHSO:

- An Audit Committee which is responsible for providing advice and assurance to the Ombudsman as Accounting Officer, and to the Executive Board on the adequacy and effectiveness of internal control and risk management. It also oversees internal and external audit arrangements which cover all areas of PHSO's work, including both financial and non-financial systems. The Committee has four members: an external Chair appointed by the Ombudsman through a process of fair and open competition; the Ombudsman herself; and two further external members.

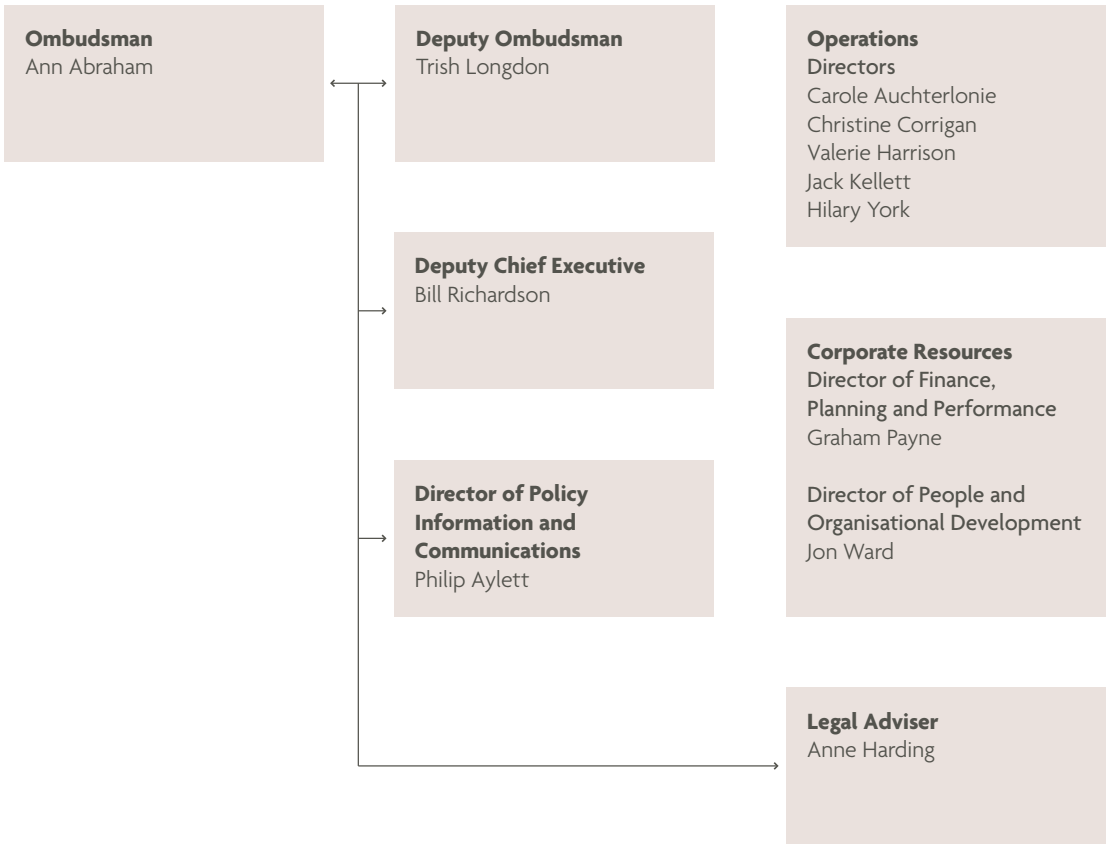
- A Pay Committee which is responsible for providing advice on pay arrangements in PHSO, and specifically for determining the pay of senior staff (except the Ombudsman herself, which is set separately under statutory arrangements). Its membership is the Ombudsman (as Chair) and any two of the external members of the Advisory Board.

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

The Executive Board

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

The Executive Board meets regularly and is responsible for co-ordinating activity across the organisation. It is the primary forum for making executive decisions about operational, resource, communications and other administrative matters in order to deliver PHSO's Three Year Strategic Plan and annual Corporate Business Plan, and for monitoring performance. The role of the Executive Board in decision making carries a recognition that on occasion there will be some issues for which the decision maker is the Ombudsman alone.



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