House of Commons
Public Administration Select Committee

COMPLAINTS: DO THEY MAKE A DIFFERENCE?

Written Evidence

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Written evidence submitted by Adam Macleod (COM 01)

Further to my letter to you of 1 April (copy enclosed), I offer the following comments on your first inquiry into the handling of complaints.

For a number of years since retiring I have written many letters to key Departments offering suggestions for improving their procedures.

Sadly **not one** of my suggestions has been accepted, without any valid reasons ever being given! Moreover, if I press Departments to give reasons, and draw attention to official guidelines on responding to correspondence, this often causes resentment, and sometimes even quite absurd claims that I am being 'vexatious' and therefore Section 14 of the Freedom of Information Act 2000 relieves the Department of any obligation to reply.

The guidelines to Departments on responding to correspondence from the public are very clear, viz:

The CIVIL SERVICE CODE requires civil servants to 'deal with the public fairly, efficiently, promptly, effectively and sensitively to the best of their ability'.

The First Principle of Public Life stresses that 'Holders of public office should act solely in the public interest.'

The Prime Minister in his foreward to the MINISTERIAL CODE (copy enclosed) has laid great emphasis on the obligation of the Government to serve the public.

However, most of my suggestions and subsequent complaints about unsatisfactory replies appear to be dealt with by very junior staff who show little or no regard for this guidance, and appear to regard their role as being to totally defend existing procedures and **never** admit to any shortcomings:

The Cabinet Office:

Over two years ago, because of this extraordinary disregard of official guidelines, I wrote Francis Maude and Nick Hurd with the simple recommendation that the Government should take seriously and consider positively any constructive criticisms or suggestions from the public.

In the absence of any meaningful reply I continued to send reminders, which simply caused resentment and the ridiculous charge that I was being 'vexatious':

Finally I wrote to Sir Bob Kerslake, Head of the Civil Service, and Sir Jeremy Heywood, Cabinet Secretary, but amazingly, despite sending them four successive letters, I got no response whatever.

The Prime Minister:

I then felt obliged to forward this correspondence to the Prime Minister since only he could deal effectively with these appalling shortcomings, and his foreward to the MINISTERIAL CODE stresses the importance of the public.

Sadly his Correspondence Unit at No. 10 has advised me that he is too busy to see letters from the public.

The Department of Health:

In 2006 I expressed deep concern that no disciplinary action had been taken against staff at Tameside General Hospital involved in the appalling deaths of four elderly patients.

A junior officer simply advised me that this was a matter for the local trust, and this 'hands off' attitude appears to have continued to the present day.

I also raised this with the Nursing and Midwifery Council, but they said that I must supply the names of the nurses involved, which I could not do because of the extraordinary secrecy surrounding disciplinary action.

In addition, I protested when Patricia Hewitt panicked over possible overspend, and hospitals were ordering consultants to work more slowly as under the new NHS Accounting System this quite amazingly saved money.

When the Atlas of Variations was published it revealed large variations in the cost of key operations. However, when I asked the Department what was being done to encourage all trusts to raise their standards to the levels of the best, I was again told that this was a matter for individual trusts. Again this 'hands off' attitude seems to still persist.

Treasury:

I have asked the Treasury four times whether they take any account of the adverse effects arbitrary cuts might cause.

In particular I referred to the cut of 10,000 staff forced upon HM Revenue and Customs, which will result in a loss of BILLIONS of pounds in uncollected revenue since each tax collecting officer collects many times the value of his salary.

I have had no reply.

Tribunals Service & Ministry of Justice:

A straightforward complaint I raised with the Information Tribunal took nearly two years to resolve, and involved no less than SIX JUDGES, TWO ORAL HEARINGS AND TWELVE FORMAL RULINGS.

Repeated complaints I have made to the Tribunal President and to the Ministry of Justice regarding this appalling incompetence have been ignored.

Office of Fair Trading:

I complained to OFT about the serious confusion that exists regarding Departmental responsibilities for tackling fraud, which is costing the Country some THREE AND A HALF BILLION POUNDS a year.

Sadly they have refused to reply on the grounds that my request is 'vexatious'.

I referred this problem to the Prime Minister nearly six months ago, but have had no reply.

Action by Public Administration Select Committee

There appears to be little evidence that previous inquiries have improved complaints procedures. I therefore recommend the following firm action:

a) Sir Bob Kerslake and Sir Jeremy Heywood to be called before the Committee to explain why they have totally disregarded the very clear Guidelines on dealing with the public.
b) They should also be called upon to agree to encourage Departments to welcome helpful suggestions from the public, unless they can produce valid reasons against this.

c) The Prime Minister should be invited to attend, and bearing in mind the terms of his foreward – should be asked to instruct his Correspondence Unit to bring to his personal attention any correspondence from the public that raises serious issues that only he can resolve.

April 2013

Written evidence submitted by WS Beckett (COM 02)

I should like to make a contribution to your exercise : Complaints: do they make a difference? Yesterday I became aware of a matter that is likely to increase the costs of the printing and publishing industry and, because it seemed to be the result of one firm misusing its monopolistic position, tried to draw the attention of the Monopolies & Mergers (now restyled as the Competition Commission) to the issue. I was told quite bluntly that the CC did not speak to individuals and that I should contact the Office of Fair Trading. I rang the OFT and, after an almost interminable struggle with the exchange operator because I had no idea which department I wanted, explained the problem and pointed out that it would affect the costs of the industry generally and seemed to be a bad practice. I was informed that nothing would be done although the matter would be 'logged'. I asked what this meant and was told - in so many words - that the matter would simply reside forever in a database. I was not satisfied with this and persisted. I was told that if I wrote in, the matter might be looked at by another department (the 'competition team') but that I would not be advised whether or not any action was to be taken. This, I replied, was not good enough since if I brought to their attention a suspect activity that was effecting my business, it was only reasonable that I should know whether or not the matter was being pursued.

Getting nowhere with the OFT - who, incidentally have an 08457 premium rate number - I rang (at their suggestion) the Parliamentary Ombudsman to suggest that there may be better ways of dealing with the public and was told (quite sharply) that to speak to the PO, I had to go through my MP! They suggested I contact the Public Administration Select Committee and thus it is I contribute to the debate you are holding. Perhaps you might consider the following:

1. Is there any good reason why members of the public cannot speak on the telephone to civil servants (sic) at a level able to address the matter in hand.
2. Is there any good reason why the telephone cannot be used in place of the written word. On the telephone I can explain a problem and instantly answer any points that need clarification. To clarify a point by post simply adds time to the exchange. (Telephones also reduce the opportunity for obfuscation which is probably the reason that letters are so close to the hearts of the civil service clerical psyche).
3. Dealing with matters by telephone reduces the number of bodies needed in correspondence.
4. Civil servants might like to reflect on the fact that members of the public - especially those devoted to wealth creation - do not have the time to write. There are also those who lack the skill.
5. It might be a good idea if the civil servants could start thinking of the public as their paymasters rather than a mass of unwashed bodies.

As for the matter in hand, I have given up all hope of the civil service acting as a champion and indeed wonder why we bother to have one. If the OFT (et al) disappeared tomorrow, I wonder how long it would be before I noticed.
May 2013

Written evidence submitted by General Medical Council (COM 03)

Introduction

1. The GMC is the independent regulator for doctors in the UK. Our role is to protect patients and to promote and maintain their health and safety by making sure doctors working in the UK practise medicine safely and to the standards we set.

2. We do this in part by investigating complaints made to us about doctors and deciding what action, if any, is needed to protect patients. In the most serious cases, we can remove a doctor's right to practise medicine.

3. We are pleased to submit evidence to the Public Administration Select Committee's cross departmental inquiry into complaints, particularly in the light of the publication of Robert Francis QC publishing his report on Mid Staffordshire, which exposed the fundamental failings that allowed very poor care to go unchecked and a culture to develop which led to catastrophic results for patients and their families. Professional regulation has a limited but important role in helping to prevent another tragedy like the one at Mid Staffordshire. We believe that by working with patients, the profession, employers and other organisations, we can play a part in helping to identify areas of risk within the system as well as fostering a culture which encourages openness, learns from mistakes and supports front-line staff to deliver high quality, safe and compassionate care.

4. We have submitted similar evidence the Review of the NHS complaints system being carried out by Ann Clwyd, MP for Cynon Valley, and Professor Tricia Hart, Chief Executive of South Tees Hospitals NHS Foundation Trust. Our Chief Executive is a member of the partners group for that review.

5. Our evidence here provides information about our role and how we handle complaints as well as data showing the continuing rise in complaints that we receive about doctors. This submission also provides information about how intelligence from complaints can be used to challenge and improve service delivery as well as how complainants can be better supported.

6. We have not addressed the wider issue of complaints procedures in the NHS, which is the focus of the Clwyd – Hart review. However, we are aware of how bewildering many patients find the current system, and we are anxious that, in any reform, complaints are dealt with effectively and fairly, that organisations see complaints as learning opportunities and that, in particular, concerns about doctors are handled well in a timely manner and at the right level.

7. We are conscious too that some complainants understandably feel that the GMC is there to provide them with some form of redress and closure, including in some cases punishing the doctor for what they regard as his or her wrongdoing. In fact our role, as made clear in statute and in the rulings of the courts, is not to punish

doctors but to protect future patients and the reputation of the profession. What we do may be punitive (such as removing a doctor's livelihood) but the purpose is not retribution or punishment. This can sometimes create a gap between the expectations of complainants and what we are empowered to do. Nevertheless, as the submission makes clear, we are determined to do everything we can to support complainants through what we know can be a stressful and difficult process for all concerned.

8. Our submission is divided into the following sections:

- our role in dealing with complaints about doctors
- the rise in complaints to the GMC
- using and sharing our complaints data
- improving our complaints procedures
- supporting complainants
- patient complaints in appraisal and revalidation

Our role in dealing with complaints about doctors

9. One of the GMC's key functions is to investigate concerns about doctors, and to decide what action, if any, is needed to protect patients.

10. We investigate complaints from a number of sources, including patients and the public, doctors and 'persons acting in a public capacity' (i.e. individuals working for public bodies, such as police officers, coroners and medical directors). We also investigate concerns that come to our attention through media coverage or referral from public organisations.

11. In the most serious cases, we can stop a doctor from practising or restrict their practice in some way. This might be because the doctor poses a risk to patients or because the doctor's conduct is likely to undermine confidence in the profession.

Triage

12. Every complaint is subject to an initial assessment by the GMC. This triage stage is to determine if the information raises a question about a doctor's fitness to practise that requires investigation.

13. If we have immediate concerns about the protection of the public, we can, at any stage of an investigation, refer a doctor to an Interim Orders Panel (IOP) hearing. The panel, which is part of the Medical Practitioner Tribunal Service (MPTS), can suspend or restrict the doctor's practice while the investigation continues if it that is judged necessary for the protection of the public. We require these hearings to be held within 21 days of the concern arising.

14. If a complaint does not fall within our remit, it will be closed and the complainant informed that the GMC will not be taking any action. In some instances, we can refer the complainant to another, more appropriate regulator, or offer advice on the steps that the complainant may wish to consider.

15. In 2011 we closed 4,914 complaints (56%) at initial assessment because they did not raise an issue about a doctor's fitness to practise. We are working to drive this number down so we get more complete and actionable complaints, through a revision of our online complaints form (see paragraphs 37 and 38), and our Regional Liaison Advisors who support patient groups and others at local level and explain when it is appropriate to refer matters to the GMC.

Write to employers (stream 2)

16. On receiving information about a doctor which on its own would not require us to take action on his or her registration, but might do so if it were part of a wider pattern of behaviour or practice, we will contact his or her employers to ask for further information about the doctor's practice. We then make a decision about whether there needs to be a full investigation.

17. In 2011 we made preliminary enquiries with employers to check for wider concerns in relation to 1,537 (17.5%) complaints. We call these Stream 2 complaints.

18. We have recently established an Employer Liaison Service which works with employers to help ensure they make appropriate referrals to us. The team also advises on how to manage concerns about poorly performing doctors and about the newly established process of revalidation, with which all licensed doctors are required to comply.

Full investigation (stream 1)

19. If a complaint raises serious concerns, we carry out an immediate investigation. This may include an assessment of a doctor's performance and, or health or obtaining an expert report. When the evidence has been gathered the findings are sent to two Case Examiners, one medical and one lay. These are senior staff employed as independent decision makers.

20. The Case Examiners have five options at this stage, from closing the case, to the most serious which is to refer the doctor to a fitness to practise panel hearing, run by the MPTS.

21. Examples of the types of cases where we may need to act include serious or repeated mistakes in carrying out medical procedures or diagnosis, a failure to examine a patient properly, fraud, dishonesty or any serious criminal offence.

22. We call these Stream 1 complaints. In 2011 we conducted a full investigation about 2,330 complaints (26.5%) in this way.

Fitness to practise hearings and sanctions

23. The MPTS runs hearings for doctors whose fitness to practise is called into question. The MPTS is part of the wider GMC but is run as a separate entity and headed by a former judge. It is accountable to Parliament its decision making is independent and it operates separately from the GMC's investigatory function.

24. If a case is referred to an MPTS panel, the panel has to make three decisions: whether the facts are proven, whether he doctor's fitness to practise is impaired and what the appropriate outcome should be.

25. If the Panel concludes that the doctor's fitness to practise is impaired, the following sanctions are available:

- to erase the doctor's name from the Medical Register, so that they can no longer practise
- to suspend the doctor's registration
- to place conditions on the doctor's registration
- to accept undertakings offered by the doctor (in effect voluntary conditions) provided the panel is satisfied that such undertakings protect patients and the wider public interest
- to take no action.

The rise in complaints to the GMC

26. In recent years we have seen a dramatic rise in the number of complaints. In 2011 we received 8,781 complaints, up 23% from 2010. Since 2008 we have seen a rise of almost 70% in complaints about doctors, a trend that reflects wider changes in society and complaints about NHS services in general.

27. Of the complaints we receive, the largest proportion are from members of the public, which in 2011 accounted for 64% of the total (5,665), an increase of 25% from 2010.

28. Complaints from individuals working in a public capacity accounted for 17% of all complaints we received in 2011.

29. 18% of complaints came from other sources, including complaints from other doctors and healthcare professionals as well as investigations initiated by the GMC. These types of cases rose by 33% compared with 2010, partly because of a significant increase in issues identified by the GMC in media coverage and partly because of

referrals from public organisations, such as patient groups and professional organisations.

30. Not surprisingly complaints from employers and those acting in a public capacity tend to be at the more serious end as they are more likely to be aware of our thresholds. In 2011 60.5% of cases which went to a hearing were originally referred by employers or those acting in a public capacity.

Using and sharing our complaints data

31. The background to the inquiry states that you will examine how departments and agencies use complaints as a source of information and challenge, to improve the delivery of public services.

32. We agree that this is important, and in recent years have undergone significant work to analyse and share the information we hold about fitness to practise concerns. In doing so we aim to turn our data into intelligence that will enable us to contribute towards improving good medical practice.

33. We are committed to doing what we can to understand the rise in complaints about doctors. Complaints to the NHS and the other regulators are also rising and the Francis Inquiry report calls for more work to understand the trends in healthcare complaints and for a greater sharing of insights among regulators and healthcare providers.

34. In September 2012, we published our second annual report on *The state of medical education and practice in the UK* (http://www.gmc-uk.org/The_state_of_medical_education_and_practice_in_the_UK_2012_0912.pdf_49843330.pdf). This drew on our data and that of others to provide an objective analysis of the medical profession and in particular the barriers to and enablers of good practice. Of particular relevance to this inquiry, it included a detailed assessment of our data on complaints about doctors.

35. We have also published a study into the factors driving complaints from medical directors and those acting in a public capacity and we have commissioned research aimed at understanding the rise in complaints from members of the public, which will be completed later this year. Rising patient expectations, online access making it easier to lodge a complaint and the heightened profile of the GMC may be some of the reasons for this increase and will be explored more fully in the study. We would be happy to share the results when it is published.

Improving our complaints procedures

36. We are committed to ensuring that we handle complaints about doctors efficiently and effectively, and in January 2013 we launched a review of our current procedures.

37. So far, the review has found that 50% of complaints about doctors received from members of the public do not give us all of the information required to make a decision promptly. Our online complaints form is an important resource as it guides patients through the process of raising a concern about a doctor. Our review has shown that where patients use the online form, we receive a better quality of information when compared to other formats such as letters and emails.

38. We are now reviewing the content, format and design of our online complaints form for patients. We plan to develop an improved form which we will test with a wide range of patient groups. We hope to see this go live later this year.

Supporting complainants and witnesses

39. The background of your inquiry states that you will consider how complainants could be more appropriately guided and supported during the complaints process.

40. We know that our processes can be stressful for both the doctors and patients involved and we have begun to implement a number of measures to provide more and better support.

41. In September 2012 we began a pilot of meeting with complainants. This involves offering to meet individual complainants at the beginning and at the end of the case. The aim is to make sure that we fully understand the nature of their concerns and that they understand the nature and purpose of our procedures. The meeting when the case has been concluded gives us the opportunity to explain the outcome of our investigation. The early signs are that these meetings are valued by complainants and that they improve the way we communicate with patients and relatives. We will evaluate the pilots and assess this means of providing complainants with more support.

42. This builds upon our previous work in launching *Patient's Help* (www.gmc-uk.org/patientshelp), our interactive guide, which provides advice on the process to follow for anyone with concerns about a doctor. This online resource helps complainants to ascertain which organisation to complain to, gives contact details for support across the UK, and explains our process once we receive a complaint.

43. All patients, including those who want to complain have a right to know what to expect from their doctors. That is why for the first time we have just produced a guide for patients (http://www.gmc-uk.org/guidance/patients.asp?WT.ac=WBPR130423) based on our core guidance for doctors, *Good medical practice.*

Patient complaints in appraisal and revalidation

44. Revalidation, which started in December 2012, is the process by which doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Licensed doctors will have to revalidate, usually every five years, by having annual appraisals with their employer that are based on our core guidance for doctors, *Good medical practice*.

45. Patients play an important role in providing information for the appraisal of doctors. Patients can and do give valuable feedback that can help doctors understand what they do well and what they could do better. With the introduction of revalidation this will be further strengthened with all doctors being required to ask for feedback systematically through an independently administered feedback questionnaire from both colleagues and patients.

46. The introduction of revalidation for all licensed doctors means that on a regular basis they will all now need to review and reflect on feedback, as well as any additional complaints and compliments they have received from patients and relatives.

May 2013

Written evidence submitted by Brenda Prentice (COM 04)

I will attempt to answer this question to the best of my ability, but please remember I am just a mum who lost a son, needlessly in my opinion, it is not an academic work of excellence! I do hope that think tanks like Joseph Roundtree, have been invited to comment.

You have asked for people experiences. I have written a book about ours, 'Andrew's Story, Living with Pancreatitis'. It tells of many problems that we all, as a family experienced. My son died because no one listened.

1. **Homelessness.** When my disabled son was made homeless an advice worker at Shelter, a solicitor, and a barrister all said an assessment made by a local housing authority broke the law in 3 places.
2. **Disability and Discrimination.** The GP ticked one of two boxes which was all the housing form required. Sadly the wrong box was ticked but all authorities up held this and did not correct the mistake. Diabetes alone is named in the Disability Discrimination Act but was not taken into account. I asked the Director of Public Health where my son would keep prescribed morphine in a safe place as the law required, and where would he keep insulin in a fridge if he was living on the streets. No answer from him.
3. **Housing Minister.** No answer to that question from our MP, the Minister of Housing or anyone else. In response to our MP, there was a two and a half page letter from the Housing Minister but she did not answer the question.
4. **MP.** When I pointed this out to our MP, he said he had done what he could and would do no more.
5. **The PCT** will no longer make assessment of this nature and local authorities go to **'Now Medical**' a private firm who will do assessments by return of post for £30. Questions have been asked in the House about this firm but it is still in existence, to its shame. It does not have anything to do with the person it is assessing.
6. **Court.** We took this to Court but Judge Cotterill up held a local authority who said my son was not medially vulnerable and was getting better. He had 5 major health issues stemming from having had his pancreas removed. He lost his job, his wife divorced him, and he became homeless. Judge Cotterill said we could not appeal, but we did go to the Court of Appeal.
7. **Court of Appeal**. Our appeal was dealt with by the Hon William Aldous retired. I phoned the office and asked, if he is retired why was he given our case? The answer was, 'he comes in and helps out sometimes when we are busy'! He up held the status quo. No more money to fight the system.
8. **Health Ombudsman.** I complained to the Health Ombudsman, eventually the GP took early retirement due to alcoholism and the Director of Public Health moved to another job. We were told none of this, we found out by asking to see the file. My son never got the help the law says he was entitled to, our complaint was not upheld. Only

by asking for access to the file find did we find that the GP had been put through the 'poor performance procedure'. My son was left thinking he was in the wrong for asking for help. Social Services had already said he had no needs.

9. **Justice**. British Justice for my son, there was none! We didn't know we could complain further to… still not sure to whom. Perhaps the Law Society? The MP didn't help, no one helped us apart from Shelter, (now closed in our area for lack of funds). The complaint that our son had been unfairly assessed got nowhere, the housing authority did not have to house him as a disabled vulnerable person, which he was. The NHS did not uphold he was disabled, which he was, (anyone who cannot digest food without intervention is severely disabled). The Health Ombudsman did not uphold our compliant.
10. **Negligence.** Our son is now dead and we are pursuing a negligence claim, this has been ruining for 3 years now. Had we have been given a 'Just' hearing, we would not have to go through the stress of this. We are pursuing this for Public Interest reasons. WE will not 'make a fortune' if we win. We were not dependent on him and so not entitled to anything, not even compensation for stress!

11. **Experience.** This was our experience of the Housing system, the NHS, and Justice System and Social services. This is just one of many complaints which we had to make over the years he was ill.

12. **Lessons learnt.** Because of what we have been through I started a charity, 'Somerset Community Care Matters'. I can say categorically that no lessons have been learnt by those who are in authority. The same problems come up time and time again. All authorities close ranks and cover each other's backs. We are given no funding by local authorities to run our charity, they would be happy if we went out of commission!

So, no, complaints do not make a difference. I do not see any improvement. If Authority was subject to the **massive fines** that had been imposed on banks, power companies and so on, they would act differently.

Your questions.

1. What objectives should Ministers adopt when considering how complaints about Government and public services provided by Government are handled?

Ministers should provide the opportunity for the Acts which govern actions, to be amended, in order to make them fit for purpose. Clearly there is work to be done to improve the framework of how authorities action the complaints themselves. Instead of being affronted, it will eventually be seen that complaints bring a gift that should be used to improve systems. No one is perfect and for authorities to refuse to accept this is foolish. If complaints procedures do not improve, try imposing large fines like other services providers. i.e. Scottish and South Energy.

The complaints procedure could be contracted out, however the risk is that those who have the contract will not want to upset their funders for fear of losing their contract and therefore their job, so that will not work.

Objects to accept, the present system does not work for complainants. It is partisan and looks after the status quo. There is no meaningful accountability. As with most problems inside authorities, if people were made to do their job properly, there would be many fewer problems. Changing systems will not address this problem. People must do their job accountably and this must start at the top. A start on this could be made by sacking David Nicolson who didn't do his job at Mid Staffs, he was got rid of by promoting him out of their way, and now we are stuck with him.

2. How effectively do Government Departments and Public services use complaints to improve services provided.

I don't think they do!

Accountable. Those who run systems, i.e. Chief Executive Officers, Ministers, should be accountable. Those who lead take responsibility and should be disciplined if they fall short of the job. They get paid enough. There is too much 'learning' and not enough 'responsibility'. Too much softly softly and not enough, 'do your job properly', that is what is needed, people to do their job. If they can't do that, they are not fit for purpose and should be sacked. (Changes to the employment law may be needed.) It is not good enough to blame the underlings when the responsibilities start at the top.

Data. Is there anything wrong with collecting data now? They just need to use the same method so we not get differing answers. For example PHOS said there had been 22 complaints about the Partnership in a given period of time the Partnership said there had been 2! I'm sure those who want to know about the problems, do.

Information. This should be available to all those want or need it. Whether or not information is acted on, leaders are still responsible for the services or departments under their control. Too many 'reports' are not enacted so they become a waste of money.

Cost. Don't know. Ask the accountants! I do know in my own case that if wrong doing had been admitted, a meaningful apology given without coercion, and changes made, I would not be claiming negligence. Whether I win or not this will cost everyone a lot of money!

3. How quickly do complaints systems deal with legitimate grievances and provide redress.

Very slowly, if at all. I've been waiting for nearly 3 years and no sign of when the investigation will finish! It gets bigger and longer by the day. Keeps someone in work I guess!

4. How easy is it to make a complaint about….. How could this be improved?

Finding a way can be very difficult, it is not easy! Removing the filter might help, but it will still not be easy. Make all authorities put a reference on the bottom of their headed note paper

and web site to 'how to take complaints further'. Make the print readable and not in minute size. The system is not meant to be easy to use. E.g. If PHOS, during their investigation, do find something amiss, unless the complainant has complained about this specifically, it will be over looked. Although how the complainant is supposed to know about new things uncovered is not taken into account!

Do complaints systems provide good access…. NO! A sympathetic approach for citizens who are less able would go a long way in helping them gain confidence. You could give a bonus for the employee who collects the most complaints and deals with them properly! That might change attitudes.

Complaints are not welcome by Government depts. or agencies. Gagging orders are written into working contracts. Whistle blowers should be embraced and rewarded.

They are dealt with, but not sympathetically.

Private business will lose customers if they are not satisfied. Employees will be spoken to, if they continue to give poor performance after possibly more training, there will be a written warning, and if that does not work, the person will be sacked. Government should try it! Instead of 'more and more training' or 'learning lessons' that they should know already, or moving people sideways with a pay rise; sack them if they can't, or will not do their job properly! That is the lesson to be learnt. David Nicolson was promoted for his part in the Mid Staffs disaster. Was this a reward for getting the population numbers down? Or just promotion for a job badly done? Are we really to take our governing masters seriously when things like this happen? Who was responsible for appointing him? Where is their accountability? When I complained to the Dept of Health that their ICAS contract was not being run properly, this was looked into and upheld; but nothing changed!!!!!!

Do complaints systems succeed in making public services more accountable…. Apparently not. When I asked how the 'lesson learnt' were going in my case, were they improving matters, I was told not to contact staff, I stressed them out! How stressed am I? There is no feedback.

Dept of Health give a contract for Independent Complaints Advocacy Service, ICAS.

I used this service. I didn't know how poor this service was until too late. I complained to SEAP, the contract holders and they admitted poor service and up held my complaint, but it was too late. PHOS had turned down my complaint, mainly because of poor presentation from ICAS. It's in the PHOS file, ICAS presentation of this very complex case is unhelpful

I asked for a copy of the ICAS contract and found SEAP had not fulfilled the contract terms and conditions. In such a complex case, legal advice should have been taken but it was not. There is provision made in the contract for such advice to be taken.

I complained to the Dept of Health, *** the contract manager. He looked into it and found nothing wrong! I asked for a review and, you can guess, it found nothing wrong!

SEAP have just had their contract renewed! So no complaints do not make any difference what so ever. Authority is unaccountable.

5. Do complaints-handling systems achieve the right balance between non judicial and judicial investigation and remedies? **NO**

Any balance would be an improvement from now, I have never seen any balance. It is that fact which upsets people so they take any other action they can.

Apologise for mistakes, saying sorry without be forced to do so. Tell the complainant what discipline measure will be taken, what changes will be made, and how that will be enacted. Give an update later on how things are going. Then people will feel listened to and less likely to take other action. (See Compensation Act 1996. Saying sorry is not an act of admitting negligence) Compensate for stress and upset caused without a fight.

Encourage a culture of openness and common sense, reward it. Sack those who blatantly don't do their job. Bosses should give the right lead and support, if this is found defective, get rid of them. Fine authorities who do not come up to what should be expected, just like the energy companies.

I don't think they do!

6. How aware are service users……

Mostly unaware!

There is little coordination or cooperation, partnership working is not something authorities seem to want to do, only pay lip service to. They all guard their autonomy, and their budget. (Not our budget, yours)

7. What lessons for complaints handling…. Frances Report. That the CEO should have been sacked but was elevated to Director of NHS!!!!!! What message does that send? That no one listens to carers who complain.

I don't know.

8. How well do Ministers deal with complaints…

If the media is watching they deal with them better than when the media is not watching. Otherwise, like the Housing Minister, they don't. I did think she should have had a medal for such a long letter, 2.5 pages and saying nothing! It is standard practise to be fobbed off by an underling who is obstructive, unhelpful and refuses to put your call through to anyone meaningful, probably more than his/her jobs worth to progress the call. S/he is the filter, first stage. First hurdle to get through! Many people fall at the first hurdle. Only those with enough strength of will, will carry on.

What do Ministers and senior officials learn… I don't know that they do! There is little evidence to show this happens. I have never had any feedback on any of the complaints I have made. Mainly because they are rarely up held! Ministers are not in office for long.

9. How should complaints about complaints systems be handled?

Authorities like PHOS should not be independent with discretion, they are unaccountable. An outside authority like a law company, should take the lead in investigating wrong doing. If they find wrong doing the authority found against should pay their bill. Less complaints over time will show if things are improving. The old boy's network should be disbanded, but how is that to be done? My experience has been that everyone let us down. There was no accountability no justice. No Judicial Review would win. I'm so disenchanted with the whole way Government works. It is top heavy with bureaucracy. The only time politicians listen is when there is an election!

I don't know if tribunals work.

Dept. of Health give contracts for ICAS. **(Independent Complaints Advocacy Service)** When I complained (it was up held!) that the contract was not being worked according to the terms of the contract, Dept. of Health did nothing! (The contract said ICAS could ask for legal advice, but it didn't take that advice. If it had been done, my complaint would have been better presented, and possibly upheld, by PHOS) No action was taken and I was told I could ask for a review, which up held the DOH position. No surprise there! I didn't know how to take this further and I was not told how I could.

It is criminal to withdraw legal aid as the only thing authority seem to understand is the threat of legal action. Legal help should be expanded, it would become cost efficient as complaints are taken seriously by authority, knowing if they don't do their job the weight of the law will descend on them. Then complaint numbers will fall. It will concentrate minds to do better and treat their consumers with more respect and compassion.

10 I don't know how other countries deal with complaints. I guess it depends on the country. I think if I lived in some countries I would have 'disappeared' long ago!

What to do.

- Change the law and stop unaccountability. Everyone should be accountable. (Action Gov)
- Enhance and expand legal aid. Cut out legal aid for those not born here and have paid no contributions. There might be some fairness then. The likes of Abo Hanser should not be given our money, time and time again, there should be a cap on how much one person can be given from legal aid. There would be more to go round the rest of us then.

- Impose fines when wrong doing at work is found, including bullying to stop whistle-blowers. (Action regulator. Who does regulate NHS? Is there a regulator)?
- Use the employment terms that private employers would use. (Action PASC or regulator)
- Sack incompetent staff starting at the top when incompetence is found. This to be determined by an independent law firm.
- Take action when staff are found to be bullied into not raising concerns. Action to be supportive of staff with concerns. Where necessary sack the CO! It sends the right message!
- Shocking that the doctor who raised concerns about Bristol Children's Heart operations at the BRI, had to go to Australia to get a job. No one here would employ him. Just unbelievable, but it happened. Should he have turned a blind eye and just let children keep dying?

May 2013

Written evidence submitted by the Blue Flash Music Trust (COM 05)

Introduction & Summary

1. The Blue Flash Music Trust is a Horsham (West Sussex) based arts and music charity. Our complaints against Horsham District Council have been 'played out' and we are therefore not asking the Public Administration Select Committee (PASC) to comment on the merits of the situation. We only appeal to the PASC to take the systemic problems and learning from our experience.

We believe the PASC should consider in detail the merits of:

- Abolishing the offices of the Local Government Ombudsman and Parliamentary & Health Service Ombudsman as a means of improving the outcomes from complaints, and reducing the cost of complaints handling; or at least, repealing the legislation that currently governs these offices;

- Actually abolishing the Audit Commission as previously announced; or at least, rotating District Auditors amongst Councils on an annual basis;

- That if any of the above offices are retained, they should be funded by the bodies complained of on a pooled basis, in proportion to the number of complaints escalated or referred. This way, there would be an incentive for public sector Complaints Departments to succeed at 'local resolution' (as Customer Services Departments generally do in the private sector);

- Replacing local government Scrutiny Committees and Accounts, Audit & Governance Committees and replacing them with directly elected public scrutinisers;

What objectives should Ministers adopt when considering how complaints about Government and about public services provided by Government are handled?

And

How effectively do Government departments and public service providers use complaints to improve the service provide?

2. The key principle is that the complaint should be ideally, and cost effectively, resolved at the point and time of conflict. There is often a lack of empowerment to customer facing employees in the public and Governmental sectors to deal with the situation and make the complainant happy at that point and time. The situation then often escalates into a costly and unsatisfactory exercise. In our case, there was an initial move in 2007 by the Council Officer in charge of the issue, to compensate us for our losses at a cost of £20,000. This was over-ruled by the Council's Monitoring

Officer (in contravention of the published complaints procedure). There followed a six year battle involving expensive Audit Commission investigations, Local Government Ombudsman investigations, legal cases, and Freedom of Information requests. Consequently, Horsham District Council won't have seen much change out of £1 million (please see www.blueflashmusictrust.org.uk for more details).

3. Often in the public sector, a formal complaint is seen by the customer-facing employee to be 'the least line of resistance' in order to escape from an awkward situation. The employee can often readily hand out a complaint form or refer the member of the public to the complaints department and effectively 'wash their hands' of the situation.

4. Complaints departments (or Customer Services as they are known in the private sector) act differently. In the private sector, Customer Services are aware of the competition and value the long-term relationship with the customer. They approach the complaint with a 'make the customer happy quickly' objective. In the public and Governmental sectors (both national and local) on the other hand, the organisation most often holds monopoly power. The 'least line of resistance' to Complaints departments in the public sector in order to meet their lengthy service levels on responding and dealing with complaints is to eventually 'face down' the complaint (due to a lack of co-operation and knowledge from the offending customer facing department) and hand out the contact details of the Ombudsman in the decision letter. The Ombudsman investigates so few complaints that there is little chance of any further comeback. Even if there is an investigation, the consequences to the organisation are almost negligible. Since Trafford Council refused to pay the Local Government Ombudsman recommended £100,000 to Carly Wright in 2008, the Ombudsman is reluctant to make any significant recommendations in order to compensate a complainant. There is little chance of any meaningful remedy to an injustice suffered.

5. Due to the Birtles judgement against us in the case of Blue Flash Music Trust v the Local Government Ombudsman (LGO), complainants should not accept the offer of an internal review by the Ombudsman (please see our website for details). Furthermore, we are not aware of any Ombudsman (LGO or Parliamentary & Health Service Ombudsman) decision being reversed as a result of an internal review. An Ombudsman decision cannot effectively be challenged in Court as the Courts have held that the Ombudsman has virtually an 'unfettered discretion'. Please see:

Re Fletcher's application [1970] 2 All ER 527

R v Local Commissioner for Administration, ex p Bradford MCC [1979] 1 QB 278

R v Parliamentary Commissioner for Administration, ex p Dyer [1994] 1 WLR 621

R v Parliamentary Commissioner for Administration, ex p Balchin (No 1) [1998] 1 PLR 1

R (Attwood) v Health Service Commissioner [2009] P.T.S.R. 1330

R (Mencap) v Parliamentary and Health Service Ombudsman [2011] EWHC 3351 (admin)

South Bucks District Council v Porter [no 2] [2004] 1 WLR 953

Bolton Metropolitan District Council v Secretary of State for the Environment (practice note) [1995] 1 WLR 1176

Locabail (UK) Ltd v Bayfield Properties Ltd [2000] QB 451

Lloyd v McMahon [1987] AC 625

R v Secretary of State for the Home Department ex parte Doody [1994] 1 AC 531

R (Jeremiah) v Parliamentary and Health Service Ombudsman [2013] EWHC 1085 (Admin)

To enter the complaints system in the public or governmental sectors is thus currently a 'lottery' with little chance of success. Complainants that remain unhappy at local resolution, if they have the resources, should therefore currently go directly to litigation.

How quickly do complaints systems deal with legitimate grievances and provide redress?

6. In the private sector, very quickly. In the public and governmental sectors, they mostly don't and slowly. The Courts on the other hand will deliver justice objectively on the basis of the merits of the case and the law (both statutory and public law). However, they will also do this slowly. Labour fought the last general election on the basis of defending public services but clearly failed in this message. In our view, this is because the electorate's experience of dealing with public servants (both employed and elected) has been increasingly poor.

How easy is it to make a complaint about a Government Department or agency and how could this be improved?

7. It is not easy to complain about the actions of local government particularly. In our case the Audit Commission once attempted to argue that it was up to the electorate. However, the electorate does not have grasp of the sufficient level of detail, an interest in the particular wayward action or injustice, and due to local political circumstances,

does not always have the means to influence things anyway (please see our website for details). When raising our complaint we were faced with a number of agencies. Furthermore, the Audit Commission tried to direct us to the LGO and the LGO tried to direct us to the Audit Commission. Both declined a meeting to sort out which items were in their domain in the Statement of Complaint. When a Statement of Complaint was finally agreed with the LGO they subsequently declined to use it and analyse the actual complaint that was made in the decision letter. We withdrew the Audit Commission investigation because the Government announced the Audit Commission was to be abolished and we no longer thought that they had the credibility or authority to deal with the issue. Unfortunately, the Audit Commission are still there three years later.

8. We would welcome the abolition of the bodies that give false assurance to the public such as the LGO and the Audit Commission. This false assurance appeared to be prevalent in the Mid-Staffs disaster. People thought that because bodies such as the Care Quality Commission and Parliamentary & Health Service Ombudsman existed that it was 'somebody else's problem' - and that everything must have been alright really. No-one felt that they needed to look for real, evidence-based reassurance instead. The banking disaster and the false assurance from the presence of the Financial Services Authority was another example. If some of these expensive and clearly non-effective protective layers to public services were removed, the public servants would naturally be under greater scrutiny by 'the people' and under greater pressure to deliver. They would also be under greater pressure to immediately 'put things right' when 'things went wrong'.

9. If such organisations as the LGO are to be retained, then there should be a clear disincentive to the public body to have the complaint referred or escalated. The national complaints handling bodies should be funded on a pooled basis by the respective services according to the number of complaints referred or escalated beyond local resolution. That way there would be a clear incentive at local resolution to make the customer happy or face the consequences.

10. Other 'false reassurances' such as local government committees should also be abolished similarly. For example, we had no idea that we were so badly and unethically governed by Horsham District Council until our complaint remained unsettled at local resolution and we started looking under the covers. We once attended a Council meeting where, when the Chairman of Scrutiny Committee got up to give his report, over three-quarters of the Councillors left the room to get a coffee. Rules dictate that the Scrutiny and Accounts, Audit & Governance Committees (AAG) should be chaired by an opposition member. However, in our area and in our opinion, the Coalition and the minority party being seduced by a turn at being Chairman of the Council, has rendered this measure ineffective. Both scrutiny Committees and AAG should be replaced by 5 – 8 members of the public; elected at the same time as local elections are held. The move would therefore not cost much. The elected scrutinisers should be nationally resourced on a pooled basis also; and

give an annual report to the electorate which includes a section on summarising complaints received and their outcome. This suggestion was put by us to the Twelfth Inquiry on Standards in Public Life and well received before being superseded by the MP expenses scandal. If the Audit Commission is to be retained - the District Auditors should be rotated around different Councils as they form too cosy a relationship with a Council over a short number of years.

Do complaints-handling systems achieve the right balance between non-judicial and judicial investigations and remedies?

11. Ideally, the right balance is for there to be no non-judicial investigations other than Public Inquiries. We strongly believe that to abolish ineffective 'protectors' such as the Audit Commission, LGO and PHSO would actually increase efficiency; eliminate a large proportion of the huge national cost that is the current complaints system; lead to better and quicker resolution of complaints locally; and actually reduce the amount of litigation against public bodies.

How aware are service users of the various ombudsman (such as the Local Government Ombudsman, Financial Ombudsman and the Housing Ombudsman?

12. People are aware - but are misled by the status and reputation of the Financial Ombudsman who will investigate and if upheld, recommend restoring people to the position they enjoyed before any maladministration took place. The bodies complained of take notice of the Financial Ombudsman too. People often wrongly think that this will be the case when dealing with the LGO or PHSO. Your best possible remedy is currently likely to be an apology from the LGO or PHSO.

What lessons for complaints handling in the NHS are emerging from the Francis Report into failings at Mid-Staffordshire Hospital?

13. The Mid-Staffs disaster was a question of culture - and as we see from other scandals like the abuse of people with learning disabilities at Winterbourne View - culture will always trump training, policies and procedures. But wayward culture is not just a health service problem. As we see from our Horsham District Council experience, it also affects areas of local government too. The culture at Mid-Staffs was to 'talk up the good news' - and 'bury the bad news'. HDC does the same. When things go wrong, the Council will likely resort to its secretive culture; and go into closed session on some bogus grounds such as "commercial sensitivity". HDC Councillors are thought to be too arrogant (as a result of an historical lack of accountability) to consider that they would make any mistakes and therefore, they will never learn from them. Consequently, they will make the same mistakes over and over again. Even if they get to hear about things, the public will not be allowed to know how the Council mistakes were made - and so can provide no input into how they might be rectified either. Freedom of Information Requests are often refused by HDC also. Prevention is better than cure of course. Most organisations will measure things in order to flag up

any potential pitfalls - so that they can deal with these issues - and/or mitigate risk on a timely basis. HDC however, doesn't want to hear any bad news - so will meaningfully measure very little. Consequently they will come to their mistakes late in the day; and those mistakes will be bigger and more spectacular as a result. The case of a £1.3 million pound overspend on the Acorn project, over two different accounting years would spring to mind. Mid-Staffs had to consider the dreadful mortality stats of course - but summarily dismissed them as 'coding errors'. The Mid-Staffs disaster was not really a case of poor regulation. Patients and families complained bitterly but were ignored. The Healthcare Commission (the fore-runner of the Care Quality Commission) expressed concerns as regulator too. However, no regulator can influence a body that simply refuses to listen, very like HDC. The Audit Commission raised various concerns about HDC and its actions over Horsham's Old Town Hall particularly. The Leader of HDC simply went into the press and attacked the Commission. The Accounts, Audit & Governance Committee of HDC then 'skipped over' the detailed concerns of the Commission a year later (too late in the day). When our Business Adviser produced his detailed report into HDC's sub-standard performance, we were simply informed that we were not allowed to question the Council. In the face of the Council's refusal to listen to anybody, the Audit Commission 'backed down' and irrationally endorsed HDC's second bidding process (which was markedly worse than the first bidding process that the Commission had previously criticised). The Francis report actually highlighted a culture that was all too familiar to us – and Horsham District Council is therefore an 'accident waiting to happen'. HDC might not necessarily cause deaths on a grand scale, but we predict on the basis of good reasoning that, if the current culture continues, there will be another major scandal at HDC in the next couple of years (please see our website for details of previous scandals with resultant losses to the taxpayer). In the meantime, we also believe the welfare of the District and particularly Horsham town will steadily decline. Time will tell.

How well do Ministers and senior officials deal with complaints raised by MPs on behalf of constituents?

14. In our experience they do not. Our MP for Horsham – Rt. Hon Francis Maude took up the issue of the Old Town Hall with the Leader of the Council and was assured in writing that it would be retained for the community. When this assurance was betrayed the MP understandably 'backed away'. This was understandable as he relies on many local Councillors to select him - and campaign for him in general elections. When Prime Minister David Cameron's Office said that the Cabinet would reply on issues about HDC which had also been raised with the Audit Commission, we received no such reply. Again this was not surprising as Rt. Hon. Francis Maude MP was in charge of the Cabinet Office and in a difficult position locally. MPs are also thought to misinterpret the fact that they cannot interfere in decisions of Councils in order to justify non-intervention. However, they could in theory, justifiably address unethical actions by Councils.

How should complaints about complaints systems be handled?

15. The Local Government Ombudsman ignored the departure from the publicised HDC procedure in our case. People should decline internal reviews by the LGO and PHSO as a result of the Birtles judgement against us (mentioned above). Independent external review is the only way to go currently therefore, but we are not sure how many of these are granted. It would be better to repeal the complaints legislation in the Local Government Act 1974 and the sister legislation in the1993 Commissioners Act - and have LGO and PHSO decisions properly and fully accountable to judicial review. Better still, abolish the LGO and PHSO altogether and have 'local resolution' decisions that are accountable to judicial review. Either way, we feel that the quality of complaints decisions would radically improve.

How do other countries handle complaints and what could the UK Government learn from them?

16. We do not currently know the answer to this. However, any countries that do not have Ombudsmen that are protected by both legislation and various legal authorities from previous cases - would make an interesting study in terms of the overall complaints handling costs and litigation costs in public services (higher or lower per head than our own); and general satisfaction with public services (higher or lower than our own).

May 2013

Written evidence submitted by the Local Government Ombudsman (LGO) (COM 06)

Summary

- Complaints can make a difference by helping to drive improvements in public services. However, the current complaints system operates like a maze and reduces the effectiveness of learning from complaints.
- Public services are provided through increasingly complex delivery methods which risks creating gaps in redress provision
- The complaints system needs to respond to changes in methods of public service delivery
- Complaints should play a clearer role in local and Parliamentary scrutiny functions
- Complaints should be viewed as a useful tool for service users, providers and policy makers

Introduction

1. The Local Government Ombudsman (LGO) helps to ensure that local public services are accountable to the people that use them. We do this by ensuring that local authorities put things right when they go wrong. This could be where the local authority has failed to provide the level of service that the public can rightly expect to receive or where the council has not acted properly in carrying out their functions.

2. The LGO is the social care ombudsman, providing a one-stop-shop for complaints about the service provided by social care providers. Our powers to investigate extend to complaints about both publically and privately funded social care. This means the public have a clear route for redress and do not have to navigate complex complaints processes in what is often a confusing social care system.

3. Complaints can make a real difference to the experience that the public have of public services. We provide examples below of how this works in practice; from using individual complaints as a tool to improve services to making use of wider thematic evidence in the development of policy and legislation.

4. However, it is increasingly difficult for the public to determine whether a service is delivered locally or centrally and as a result more and more complaints will overlap the respective jurisdictions of the LGO, the Parliamentary and Health Service Ombudsman and the Housing Ombudsman. This leaves the public with a complaints maze to navigate in order to seek redress. It is this complaints maze that stands in the way of complaints making the difference in a more impactful and frequent way.

5. We have focused our response on the four objectives of the inquiry, the effectiveness of current complaint handling, its accessibility to users, the impact of complaints on policy and provision and reforms of the complaints process.

6. We would welcome the opportunity to present oral evidence to the enquiry.

Effectiveness of the current complaints handling

7. For complaints to make a difference they need to be handled well. Good complaints handling has to be rooted in the principles of: fairness; effectiveness; openness and transparency; and accountability[1]. A recently commissioned independent external evaluation of the LGO, to assess our service against those principles, found that "The LGO's decision making procedures meet best practice in the ombudsman community in terms of fairness, openness and transparency" and we strive to continue to embed these principles in our daily work[2].

8. The wider complaints system also needs to meet these principles. Routes to redress must evolve in line with these principles to match changing service delivery. The provision of public services has gone through dramatic change. The divide between services delivered between central and local government has become increasingly blurred. In addition the areas of service delivery of individual government departments are becoming increasingly complex. Areas such as welfare and health now involve both central and local government departments. At the same time an increasing range of private, voluntary and public organisations are involved in complex delivery structures.

9. These changes have led to an increasingly complex 'complaints maze' that the public are required to navigate in order to seek a remedy when public services let them down. We have illustrated the confusing array of channels that the public face when seeking to bring a complaint in the attached complaints maze diagram.

10. In this changing environment the LGO has itself adapted, responding to jurisdictional changes which allow us to consider complaints about private social care providers. We are increasingly working closely with other organisations and use that close co-operation to provide the public with a clearer path through the complaints system.

11. For example, we use our statutory powers to conduct joint investigations with the PHSO and Housing Ombudsman to provide the public with a single investigation and a seamless route to redress where their complaint overlaps our jurisdictions. The public do not have to separate out different issues and establish which ombudsman to approach. We also work closely with our regulatory partners, such as the Care Quality Commission, and are currently exploring practical ways to share more complaint information.

12. However, despite close working between respective complaint bodies, the redress system still remains complicated for users to navigate, as the complaints maze diagram illustrates. The consequences of this for the public were clearly expressed in a

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[1] Ombudsman Association, Criteria for the recognition of Ombudsman Offices - http://www.ombudsmanassociation.org/docs/OA-Rules-Schedule-1.pdf

[2] External Evaluation of the Local Government Ombudsman in England **http://tinyurl.com/ce8pzf3**

2010 Ipsos MORI[3] customer satisfaction survey for the LGO, which found that users are often "exhausted" by navigating complaint procedures and by the time they can bring a complaint to an ombudsman they are "frustrated".

13. Despite our work with other bodies to ensure that users are not left without a course of redress, there are still gaps in access which will require legislative reform. The new proposals contained in the Children and Families Bill will leave users confused over the appropriate route to redress. The proposal to more closely integrate the provision of education, health and social care for special educational needs (SEN) users will help produce holistic provision. The fragmentation of complaints handling will only undermine this integration. Complaints about social care and the admission procedures of schools can be handled by the LGO and those about health handled by PHSO. However complaints about the internal procedures of schools will not be considered by an independent ombudsman and will ultimately be handled by the Department for Education. The Committee's Inquiry provides a useful opportunity to identify and map such gaps in public service redress.

14. The confusing array of routes to redress, or gaps in complaints provision for public services, inevitably challenges the effectiveness of the complaints system and limits the opportunities to learn from complaints. A move to a more integrated and comprehensive approach to complaints about public services will be central to improving the use of complaints as a tool to drive service improvements.

Accessibility to users

15. As seen above, the effectiveness of the complaints system is closely linked to the public's ability to access and navigate it. Where the complaints maze impacts upon the effectiveness of the system it also hinders users' accessibility to redress. LGO plays an important role in making the system more accessible to the public. During 2011-12 our Intake Team handled almost 21,000 complaints and enquiries from the public by phone, email, web and post, and that number is growing. As a free and non-judicial service we provide the public with a service that does not require them to have specialist knowledge or to appoint a lawyer. Our informal, inquisitorial process is focussed upon making our service as easy to access as possible.

16. Our role as the ombudsman for adult social care provides one such example of this in practice. Our powers allow us to consider complaints about social care provision that is both publically and privately funded. This provides the public with a very clear route to redress. As a 'one-stop-shop' for social care complaints the public can feel reassured that there is only one place that they need to go when their complaints have not been resolved. This is a good example of where the complaints system has responded to the changing methods of public service delivery.

[3] Ipsos MORI Understanding expectations: customer satisfaction research for the LGO 2010
http://tinyurl.com/cnubxns

17. We also work closely with front line complaints handlers across our bodies in jurisdiction to ensure that they are properly signposting people to us. We provide quarterly newsletters to highlight changes or trends so that they can improve the service they provide and ensure that complaints that need our input reach us easily and promptly.

18. We do recognise that we will always need to do more to raise awareness of our service and to ensure that the public know where we are when they need us. As there are a number of different ombudsman schemes, covering both the public and private sector, it is important that we do not work in isolation when seeking to explain our role in the complaints system. We would welcome a more co-ordinated approach to raising public awareness and have begun to discuss with our ombudsman colleagues how we can best achieve this.

19. For complaints to make a difference the public must first be able to access the complaints system. Simplifying the complaints maze would make the single biggest impact on the accessibility of the complaints system. A single access point for all complaints, as is the approach in Wales, would be a considerable first step down this path.

Impact on policy and provision

20. Every year the LGO investigates around 11,000 complaints against local authorities and social care providers. This has given us an extensive knowledge base and a unique insight into frontline service provision. We have shared this intelligence with service providers and policy makers. We submitted evidence to Parliament during scrutiny of the Children and Families Bill and the Draft Care and Support Bill. Our input was welcomed by both those Committees and was referenced in their consideration of the legislation.

21. We also ensure that learning is utilised by Government throughout the process of policy development. In November 2012, we published a focus report that highlighted issues with the use of bailiffs by local authorities. The report drew upon case examples to illustrate the problems that the public were facing. This report was shared with the Government and has been used to help inform the Ministry of Justice's approach to the future regulation of the bailiff industry.

22. Feedback from complaints provides direct learning to front line services. Prior to investigating a complaint we ensure that the local complaint procedures have been exhausted. We do this because this where learning is at its greatest. Once an investigation is complete, we provide feedback and recommendations for improvement and we identify and highlight systemic failings to prevent the same issues from happening again.

23. We share our insight widely through a variety of means. We publish reports of both individual investigations and on thematic issues. In 2012-13 we published around 50 such reports. We deliver training directly to complaints handlers in local authorities.

Over the last year we delivered more than 60 courses to local authorities in England, focussing upon effective complaint handling. We also provide local authorities with an annual letter that sets out their complaints statistics for the last year and highlights any specific issues of concern. These letters are published on our website so that the public also have access to the information. Through these different channels we are ensuring that service providers learn from complaints and use that information to improve their services.

24. LGO will be publishing the decisions made on all complaints received from 1 April 2013. This information will be made available on our website so that policy makers, public bodies, service users and academics can have easy access to our complaints data. We are the first public sector ombudsman in England to publish such comprehensive information which we believe will have a significant impact on the ability to use complaints data to inform policy and to improve service provision.

25. Complaints are also an important tool in the scrutiny of public services and can support existing accountability mechanisms. *Aiming for the Best- Using Lessons From Complaints to Improve Public Services,*[4] a joint publication by LGO and the Centre for Public Scrutiny, provides a guide for councillors and overview and scrutiny committees on learning from complaints in business planning, commissioning and scrutiny arrangements. It highlights the important link between complaints and existing scrutiny functions.

26. There is an opportunity for complaints to be used more to support the scrutiny role of elected councillors. Recent research carried out by the Local Government Information Unit showed that over two thirds of councillors supported the idea of using ombudsman data more to enhance the work of their committees. Over the coming year we will be engaging with local elected officials to support the better use of complaints in councillors' scrutiny of local public services.

27. The use of complaints data by LGO to impact on policy development and on service provision clearly demonstrates the potential that complaints have to make a difference. We will continue to use our information in this way and seek opportunities to further increase our impact. However, it is also important for policy makers, commissioners of services and scrutineers to recognise the value of complaints and to take a more active role in using such information to make a difference to the service the public receive.

Reform of the complaint process

28. Complaints can make a difference and the failings the public experience in their interactions with public services may be minimised, or even prevented, if complaints are listened to and acted upon. While good complaint handling can have a range of benefits in service provision, this can only be realised if it is properly integrated into

[4] http://www.lgo.org.uk//GetAsset.aspx?id=fAAxADQAMgAzAHwAfABGAGEAbABzAGUAfAB8ADAAfAA1

service provision. This will include ensuring that all staff learn from complaints and view them as an insight into the consumer's voice and an important tool in service improvement. This principle however should not be viewed as solely for individual providers but across all levels of government including senior policy makers.

29. Often complaints are treated as the responsibility of individual staff or departments. However complaints redress should be ingrained into the work of all government departments and public services and fully considered throughout the development of policy. A holistic approach to complaint handling can ensure that policy is consistent across government and schemes are able to cooperate and work closely together. Where service provision is often fragmented, greater joint working between complaint schemes will be necessary in order to prevent gaps appearing and to provide redress should something go wrong.

30. The experiences of complaints in other nations, such as Scotland and Wales, provides an example of how a more joined up system gives the public a clear and accessible route to redress. The Law Commission's report on Public Service Ombudsmen[5] looked at these examples when they made proposals for reform, particularly focussing upon the need for greater collaboration between the various public sector ombudsmen in England. Our view is that through encouraging more joint working across the complaints system, improving the profile and accessibility of that system and reducing the number of complaint triggers and points of access, reform of the complaint process can simplify the complaints maze.

Conclusion

31. As a key part of the administrative justice system, the LGO understands the difficulties users can encounter when complaining about a public service. Service users can often face a fragmented system with several different routes to redress. As the extensive reforms to public services start to bed in, it is fundamental that the complaints redress system evolves to match new service provision and ensure that all service users have an accessible and appropriate course of redress for their complaint. The complaints maze is a significant hurdle in providing the public with an effective and accessible route to such redress. LGO and PHSO are already committed to closer harmonisation of our processes to achieve greater clarity. The Committee's inquiry provides an appropriate opportunity to consider how we can develop this work with others to deliver the practical actions and appropriate reform that will simplify the maze and ensure that complaints do make a difference.

May 2013

[5] The Law Commission – Public Service Ombudsmen (2011)
http://lawcommission.justice.gov.uk/docs/lc329_ombudsmen.pdf

THE COMPLAINTS MAZE

Local Government
OMBUDSMAN

IPPC
Police
Police/ Policing
Prison and Probation Services Ombudsman
Prisons and Probation
National Planning Issues
Courts and Tribunals
Courts and Tribunals service
Central Government Departments
Planning
Transport
Police and Crime Commissioners and the Mayor's Office for Policing and Crime
Internal Drainage Boards
London Development Agency
Urban Development Corporations Homes and Communities Agency
Transport for London
London TravelWatch
Disabled Parking
Driver and Vehicle Licensing Agency
Driving Standards Agency
Highways Agency
Maritime and Coastguard
Vehicle and Operator Services Agency
Vehicle Certification Agency
Fire and rescue and London emergency planning authority
Taxation
Local Authorities/ GLA
Benefits administered by local authorities
Welfare and benefits
Local Taxes
Health and Wellbeing Boards
Local Authority role in health provision
Local Healthwatch
Health
Benefits administered through central Government
National Taxes
Housing Ombudsman
Local Government Ombudsman
CQC
NHS
Department of Health
British Parliament
Housing benefit homeless
Housing
PHSO
Health related Provision
Mental Health
Housing providers Local Government role as social landlords
Admission and exclusions of local authority run schools
Local authority early years provision
Public and Private social care local authority
Social care
NHS
Internal procedures of schools, academies
Education

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Written evidence submitted by AW & I Tanner (COM 07)

(1) Well if you are an individual complainant, you are easily throttled by the entrenched fraudulent procedures, but if complainants form themselves into well-organised groups like the 'Hillsborough' and the 'NHS' protesters— it still takes 20 years to get a hearing—such is the power of the public sectors corrupt complaints machinery.

(2) It can be seen that Complaints only make a difference if one is prepared to sacrifice oneself in trying to obtain justice from the abusive state-machine. The 'Hillsborough' and 'Mid Staffordshire Hospital's' aggrieved families struggled for over 20 years against the public sectors self-serving fraudulent complaint procedures, where all sorts of chicanery, like the 'alteration of facts' as used by NHS officials and police, helped 'put down' genuine complaints by bereaved families.

(3) Instead of being open and accountable, complaint procedures have been turned on their head. Instead of helping the aggrieved public, complaint procedures are often manipulated by self-serving officials who will 'put down' complainants and whistle-blowers without giving a damn as to the injustice of their acts.

(4) We have so many active public sector cover up routines operating against the public interest that they have become an assault on our liberties, they also curtail our justice system. Corruption within the public sector is so vast, that the normally quiet subjugated citizens are forced to protest. Citizens are becoming organized—simply because Parliamentarians have failed to protect them from despotic officialdom.

(5) Too many individual complainants are forced to give up, as they are unable to face the powerful machinery of government that spills out self-serving lies and deceits associated with complaint procedures. Once a complainant has been 'put through the mill' there is no one else to turn to. MPs are not interested in tackling public sector fraud.

(6) The numerous fraudulent complaint procedures are indicative of something more sinister, they cover up a multitude of entrenched public sector sins; as seen

when £14million was stolen from our coffers in order to pay off NHS whistle-blowers from divulging evil and corrupt acts against many of the UKs sick and vulnerable patients.

(7) The formation of numerous well-honed cover up cultures is indicative of just how much abuse of 'good governance' has really taken place in the past—corruption of our democracy shows how many of us have lost our destinies to insular party hack governments.

(8) **Public sector corruption is said to be the use of Public Office for private gain; this would apply to the numerous inept officials who have been promoted by top civil servants to all Government departments; where they are paid enormous unearned salaries, enormous unearned perks and large unearned bonuses year in year out for failure. The Home Office, the UKBA, the HMRC and the NHS etc are just a few of the failing government departments who abuse the public purse in this way.**

(10) We have often claimed that the promotion of inept officials to high office is the cancer at the heart of government. The public are bemused as to how Parliamentarians allowed the self-serving 'complaint system' to thrive and become so entrenched. How such deliberate abuse by officials was allowed to flourish within the Mother of Parliament, destroying much 'good governance' at all levels. MPs should be ashamed that the complaint system had got so 'out of hand'.

(11) It is often pointed out that "Large scale bureaucratic administration places decision makers so far from citizens that they lose sight of their public service mission, and come to focus primarily on the nourishment of their own powers as an end itself". This is so typical of the Whitehall regime.

(12) Too many individuals with genuine complaint who try to 'clean up' complaint procedures suffer from accumulative years of despair, as they are eventually forced to 'give up' as the corrupt machine grinds them into the ground—throttled by fraudulent officials.

(13) We first suffered unjust treatment from a Revenue/VOA employee who wilfully neglected to perform her duty re our appeal and wilfully abused our rights without any justification. She 'manufactured' a ghost employee 'Mrs Gupta', and

then informed us that 'Mrs Gupta' was looking into our appeal. 18 months later we found that 'Mrs Gupta' did not exist? We and our appeal were being bamboozled by contemptuous public sector corruption.

(14) We continued with the fraudulent complaint procedures and eventually faced a biased Ombudsman who took sides with the Revenue, who claimed that the manufactured 'Mrs Gupta' came about by a misunderstanding caused by 'internal agency jargon'. We asked the ombudsman to resign; we were then subjected to ombudsman inspired intimidating 'phone calls over three evenings- my wife was scared!

(15) During our years of struggle against the complaints procedures, we found the Ombudsman had exonerated the fraudulent acts by the Revenue/VOA; she also exonerated the malfunctioning ICO; while the ICO was also exonerating the Revenue/VOA. The closing-of-ranks indeed.

(16) We were at various periods 'hung out to dry' by the Revenue/VOA, by the Ombudsman and by the ICO, it took 2 years for the ICO to produce a biased Decision Notice that claimed several times that the Revenue/VOA were accountable, when they were clearly not. We informed PMs, Ministers, and MPs of our plight- some of our letters were sent from one department to another- the ideal way of 'hanging out' a complaining member of the electorate.
(17) I was hoping to question the miscreant Revenue/VOA employee at a Tribunal, but the Revenue employee who had given us so much aggro, had been hidden away behind the DPA, and was not available for questioning.

(18) What we learned as complainants was, that once you had been 'kicked in the teeth' by the complaints process, there was no other means of protest—the crooked procedures were the only channels open to you?

(19) In frustration we once wrote to Justice Minister Jack Straw and suggested that 'citizens with genuine complaints against officials' needed 'open courts' so they may circumnavigate the crooked complaints procedures as run by civil servants etc'. No answer.

(20) The long years of public sector deceit and fraudulence against citizens and whistle blowers with genuine grievance should have caused enormous disquiet in Parliament- but it never did.

(21) Parliament and the Cabinet Office etc were purposely remote from the crude dysfunctionality of the fraudulent machinery of government. The public sectors numerous Mafia style cover-up cultures were protected by powerful top officials who put a 'lid' on much public sector fraudulence.

(22) There has grown within the public sector powerful "institutionalised self-protective routines' administered by officials who are determined to deny justice to complaining citizens. These officials have control of the complaints procedure, and wield disproportionate cover-up influence that protects even the most-vile of public sector personnel- they protect those who deny care to the sick and vulnerable- and they even give active protection to paedophiles operating within government run child-care homes.

(23) The corruption within the public sector is vast—corrupters have infiltrated the complaints system as to make it almost 'null and void', Hillsborough families had to fight for 23 years before they could break through the injustice barrier- the individual complainant has little or no chance of success- that's the reality of our Orwellian self-serving complaints procedures!

In relation to the Public Administration Select Committee's first inquiry entitled Complaints: Do they make a difference, I offer the PASC my encounters with fraudulent government complaint procedures as run by officials and civil servants etc.

Whilst the lay-out of information given here may not be precisely what the Committee is looking for; it is a true account of the gross abnormal protection given to a public sector miscreant—in short I protested at the corrupt Revenue/VAOs acts against me—and eventually faced government lawyers within a Tribunal?

We have recently asked the PM to support the National Corrupt Officials Register.

Here is my account of how citizens who use the government complaint procedures are treated. My case will help show why many complainants give up, because if one persists in tackling and exposing the often fraudulent government procedures in the hope of 'cleaning things up'—one is in for a seriously stressful time. It often takes years of struggle against the UKs powerful and undemocratic government complaints machine as run by civil servants etc.

(1) I wrote 22nd March 2003 to the *** Revenue Valuation Office and made a Banding Appeal- what should have been a very simple procedure, something that I was entitled to? It turned out to be a revealing nightmare re public sector complaint procedure cover up. 28 March 2003 a Revenue Valuation Office official claimed by letter that our appeal was 'out of time' this was false (there was no time factor applicable). She also claimed that the appeal was 'invalid' another deception- it was a dismissive judgment. I had been to my local library re info as to Banding Appeals, I knew that she was wrong.

(2) The VOA had failed to survey the area, and without any evidence available to them as to whether we had a case or not, an official saw fit to take a belligerent stance against our simple appeal and claimed the appeal was 'invalid' (About two years later a VOA manager "Apologised that our property was not inspected, as an inspection should have taken place)

(3) On the 20 May 2003 realising that our appeal was being ignored we again h wrote to the Southgate Revenue office and asked if someone would answer our letters. Responding to our several requests for a 'report' that we were entitled to; a listing officer wrote 4th June 2003 "I have read and noted your remarks, and a 'report' has been raised in this office. The report has been allocated to Mrs Gupta, who will be in touch. Not hearing from Mrs Gupta, we resorted to writing

numerous letters asking for a copy of the Gupta Report.

(4) There was a period when this aggressive official sent us Notice of Withdrawal Forms, arrogantly requesting that we sign them, it was a blatant attempt to get us drop our appeal, and sign away our democratic right to an appeal, we refused to sign; she sent more forms to sign. She was a belligerent civil servant determined to sink our claim, we had to ask the Southgate Revenue/VOA to stop sending these request to sign Withdrawal Forms. There was a constant air of intimidation coming from these nasty public sector officials.

(5) We constantly challenged the officials claim that our appeal was 'late' or 'not valid' to no avail; some 14 months after our initial request for an appeal, we asked the VTS Tribunal to look at our case; it found; "That our proposal was valid the listing officer should have treated our appeal as valid". We had been put through 14 months of aggravation trying to nail these Revenue/VOA lies and deceits.

(6) Instead of the Revenue/VOA accepting that they were at fault after the VTS decision in our favour, they acted as though they were 'miffed'. We were then told by the Revenue/VOA that we would have to start the appeal proceedings all over again? Who allows such despotic civil servants to be so aggressive against citizens who have genuine complaints?

(7) I was at the time due to have 7 weeks of radiotherapy for cancer—I simply could not face 'starting up all over again' against corrupt Revenue VOA officialdom—I was forced to abandon my appeal that had been so fraudulently strung out. After the cancer treatment I decided that I would 'fight back' and help disclose the entrenched corruption that had been allowed to fester across the public sector—I was once a front-line soldier a war pensioner—I had become somewhat traumatised by the many people within the Establishment who could abuse the electorate who had genuine complaint. Shades of the 'Balchin's case—Hillsborough and the latest NHS abuse of power.'

(8) Some 18 months after being promised a 'Mrs Gupta Report', we discovered she had never existed in our case? Mrs Gupta turned out to be a 'Ghost' employee manufactured to help destroy our appeal! Despite our writing for months asking for copies of the Gupta report—no Revenue/VOA official had 'let on' that the miscreant official had demolished our appeal by handing it over to a non- existent Revenue 'ghost' employee?)

(9) We saw this as collusive corruption by the Revenue/VOA trying to get error-strewn official 'off the hook'. Southgate Revenue/VOA once held an 'internal investigation' they produced a ridiculous verdict claiming that the individual official who had given us so much aggro had acted with the 'Best of intensions'- we saw this as the usual internal whitewash.

(10) On another occasion, Southgate Revenue/VOA, with self-protection in mind said that they did not think the actions taken against us by the official were deliberate. We claim however, that when all the wilful acts of deceit are put together they give a much clearer picture of the belligerence shown against us. The Revenue/VOAs aggression against our simple appeal could not have been 'accidental'. The miscreant official acted with the unswerving arrogance of a contemptuous, unmanageable, yet well-protected public sector 'loose-cannon'.

(11) Our Revenue/VOA abuser was not a gauche school-leaver prone to mistakes; but she has to be seen as an irresponsible civil servant who knew the ropes, and was well aware of the aggressive 'corruption of good governance' that she created.

(12) We had been force-fed a corrupt Revenue/VOA invention—a 'Ghost' employee—we protested- the VOA then tried to claim the promised Gupta report had come about because of mistaken 'Agency Internal Jargon'. We had chased up the promised Gupta Report during 2003/4—no one had made the excuse that the promised report came about by an accident due to 'Agency Internal Jargon'—it was an afterthought!

(13) At a later stage the parliamentary ombudsman also ran with this flippant 'Agency Internal Jargon' excuse, in order to get the VOA 'off the hook'. When we challenged the ombudsman as to the corrupt invention of the 'ghost' employee Mrs Gupta—she did not reply?

(14) The ombudsman had tried to cover up this corrupt 'invention' of the 'ghost employee' as though it had never happened? She claimed she had seen no evidence of fraud or corruption! The ombudsman failed to see the Revenue/VOAs utter contempt in allowing us to write for months on end asking for copies of the non-existent Gupta report- without reply! The ombudsman was purposely blind to our struggles as victims of public sector deceit- yet was

prepared to state that she saw no fraud or corruption.

(15) We asked the ombudsman to resign; we were then hit by the ombudsman's orchestrated Survey Team's 'evening phone calls', asking us if we would take part in answering questions relating to a spurious ombudsman's survey.

(16) We said no thanks to the first phone call saying that we did not want to take part! They persisted for another two evenings. We were being got at because of our call for the ombudsman to resign and our protest against public sector corruption in general. My wife became frightened as to what might happen next? A possible knock on the door?

(17) We put it to the Ombudsman that, 'When one is asked in the street to take part in a 'survey' and one refuses, the person doing the survey steps aside, and let's one walk away— they are not aggressively pursued by evening phone calls! This jackboot of an ombudsman has no respect for our human rights. **We had complained about public sector corruption, and were being bullied for it!**

(18) What is frightening is that the 'corrupt machinery of government' that gives so much 'gold plated protection' to uncivil servants, allows such misfits to go 'off the rail' and still remain safely untouchable as they abuse members of the public in such a freewheeling manner!

(19) At one stage the Revenue/VOA Executive asked us to 'Draw a line' under what had gone on, they were asking us to help hide their numerous fraudulent managerial shortcomings.

(20) This particular Revenue VOS official, who was supposedly in charge of our appeal, was a nasty piece of work as seen in her deliberate misuse of power, when I asked the ICO had other members of the public complained about her, she was then hidden behind the DPA.

(21) Citizens now realise just how vast public sector corruption against the individual complainant has become! We realised as whistle blowers, that once you have criticised the crooked Whitehall machine—it simply turns around and kicks you in the teeth—justice for the electorate with honest complaint is simply not on the Whitehall agenda.

(22) When one becomes a critic of governmental complaints procedures, there seems to be a 'closing of ranks' from all quarters, life is purposely made so complicated for critics and whistle blowers. Complainers against corrupt government procedures are seen as fair game for abuse of their democratic rights—one gets fed-up at times being 'hung out to dry' by all and sundry—one could explode—it's difficult to be nice to civil servants and officials who are trying to screw you into the ground.

(23) One gets further annoyed and retaliates against the ever-more layers of incompetence and wilful neglect that becomes part of the 'hanging out to dry' routine; as seen in our following letter to the then seriously inept ICO. We had written to the ICO re their neglect in our case back in 2005—a year later 2006 we were complaining about the same sort of neglect?
So on the 13th Nov 2006 we wrote criticising the Information Commissioner as follows:
"On the 16th Nov 2005, a year ago we had occasion to bemoan the fact that the ICO not only failed to answer our letters (re corrupt acts against us),but failed to acknowledge that the letters had indeed been received. This of course we viewed as sheer incompetence. Now in November 2006 the same thing has happened again, we now view this second episode as pure contempt, bordering on pure fraudulence and corruption of public duty..... It may be that you have closed us down because our attitude has become hardened from years of collusive public sector evasions and deceit....."
Later in the letter we wrote;
"We are reminded that having reported to the ICO about the corrupt activities of the VOA, the ICO, despite being called in by us to investigate this somewhat despotic agency, falsely indicated to us that the VOA had made an 'honest oversight'? We told the ICO that we had suffered from too many VOA 'oversights', that we were unhappy with the ICOs 'slap on wrist' judgments. We were unhappy that the ICO were not able to provide us with information re the Revenue/VOA miscreant's possible aggression against other honest members of the public who had genuine complaint."

(24) The confrontational dialogue in our letter above was brought about by years of official ineptitude and deliberate official delaying tactics used by the corrupt government machine.

(25) At this time the inexperienced ICO boys had followed the Parliamentary

Ombudsman's action and closed down our case. At times all these government agencies seemed to be in collusion—we were being hung out to dry by the Revenue/VOA, the ombudsman and the ICO

(26) Despite the fact that I had been corresponding for a couple of years with the Revenue/VOA, the Ombudsman, and the ICO about a Revenue employee's corrupt acts against me; when I attended a Tribunal! faced Revenue and ICO lawyers. The Revenue/VOA corrupt acts that I had been fighting against for a number of years were not on the agenda? The corrupt acts against me were not going to be discussed. How could that be? The Revenue miscreant who had given us so much aggravation was not there for questioning, being hidden away behind the DPA. The Revenue and ICO lawyers talked of legalities—they were bamboozling me with chicaneries; my case was stopped as it was deemed under some 'legal ruling' that I had "no chance of succeeding"? Kafka and Orwell would have been in stitches!

(27) No one within the Tribunal mentioned the Revenues corrupt acts against my appeal, there was no mention of the Revenue/VOAs corrupt invention of the non-existent 'Mrs Gupta' who had been 'put in charge' of my appeal. I questioned the ICO lawyer as to why the Decision Notice had intimated that my claims to expose the nastiest of civil servants "maybe unsubstantiated or malicious". I was being 'stitched up' by a fraudulent collusive complaints procedure that had all the hallmarks of a powerful Mafia style 'establishment protection racket.' The nasty Revenue civil servant was given gold-plated governmental legal protection, whilst I an old war pensioner could not afford lawyers.

(28) We were 'hung-out' for two years for a ICO Decision Notice that was extremely biased—it claimed the Revenue VOA were 'open and accountable' on several of its pages; Paragraph 36 fraudulently intimated that my assertions against the nasty individual were no more than 'assumptions'? The extremely biased Decision Notice declared rather fraudulently, again in paragraph 36 that our accusations against the VOA miscreant "maybe unsubstantiated or malicious".

(29) We have a letter that gives the lie to the Decision Notice's flippant abuse of justice; it reads:
"Mrs xxxx professional conduct and behaviour towards you and your wife whilst handling your council tax affairs were less than satisfactory". This gives the lie to

the ICO's put down that our claims were no more than 'assumptions'." We have other evidence as to her incompetence.

(30) I like many complainants/whistle blowers suffered accumulative years of despair. In our case having first suffered unjust treatment from a Revenue/VOA miscreant, and a corrupt complaint procedure, I then come across a biased Ombudsman, who eventually subjected us to intimidating evening phone calls.

(31) We were then 'hung out' over a 2 year period between the Revenue/VOA, the Ombudsman and the ICO who were guilty of prolonging the saga and the Decision Notice. The ombudsman tried to exonerated the Revenue/VAO corrupt acts; she also exonerated the malfunctioning ICO; whilst the ICO also exonerated the Revenue/VOA- a closing of ranks indeed.

(32) I faced government lawyers within a Tribunal who controlled the hearing of my case. (They were unhappy at the way I had criticised the ombudsman?)

(33) Neither the corrupt acts by the Revenue miscreant, nor the miscreant herself were on the Tribunal agenda. I was unable to question the person who had given us so much grief. The case was closed quickly as it was deemed that I had no chance of success?

(34) Paragraph (36) within the Decision Notice states that my claim against the miscreant, who had given us so much agro, was mere 'assumptions'. Also paragraph (36) declares erroneously that (despite our years of struggle against a civil service miscreant) our complaint maybe 'unsubstantiated or malicious'. The ultimate in public sector 'put downs' of 'whistle-blowers'.

(35) We wrote to Prime Ministers, Ministers and MPs and Media about corrupt complaint procedures- no replies. We asked Minister Jack Straw for 'open courts' so that abused citizens could circumnavigate the crooked complaints procedures as run by civil servants- it is quite ridiculous that Parliament has allowed civil servants and officials to 'self-police' their own corruption of 'good governance'.

(36) The British people, because of parliamentary neglect, have lost much of their democracy to the fraudulent 'government machine'. Many public sector abusers of our democracy, with stealth are capable of imposing their own illegal 'made up rules' upon the long suffering British public!

(37) We ask the PASC to consider who are these 'well organised' Mafia style abusers of good governance? Are they from a recalcitrant somewhat defunct political party or maybe they have Masonic connections? The question is 'who allowed such public sector miscreants to become so powerful?

May 2013

Written evidence submitted by University of Oxford (COM 08)

Parliament's Ombudsman Service

We would like to submit the following comments for the Committee's consideration.

We believe that there is currently a major opportunity to develop the PHSO's function and thereby bring about fundamental improvement in public services and save substantial public expenditure. The key to this is to review the role and function of the PHSO in the context of public services.

We see two major shifts occurring currently, which create significant opportunities if they can be grasped:

A. **A major shift in private sector dispute resolution away from courts and towards ombudsmen and similar 'alternative dispute resolution (ADR) schemes.** We can see a number of examples of this within this country, and the trend will be accelerated as a result of the recent adoption of EU legislation, a Directive on Consumer ADR that will require full ADR coverage for traders in almost all sectors for consumer-to-business disputes by 2015, coupled with the creation of a new ICT platform for online dispute resolution (ODR). This requires the UK to undertake a fundamental review of the architecture of all of its ombudsmen, and offers a golden opportunity to adopt a modernised and highly effective system, if suitable reforms are made.

B. **Inevitable reform of the PHSO architecture.** You will be aware of a series of concerns with the current architecture of the PHSO systems, and a desire to enable complaints about public sector bodies to be dealt with to greater effect. The Francis Mid-Staffordshire NHS Report is timely: it raises the question of how an ombudsman system can assist in preventing things going wrong so that an *ex post .facto* inquiry like Francis becomes unnecessary.

In redesigning the system, we suggest that a very simple model needs to be borne in mind. It is based on a business quality system, and has the following components:

1. **Reducing the incidence of problems**. This needs good quality advice for 'consumers'. We suspect that the advice element can be improved: the issue is not just one of the quality of advice, but making it easily accessible to citizens, and understandable by different recipients.

2. **Capturing complaints (and resolving them).** People should have easily identifiable places where they can take their complaints to. There should be two tiers: one 'in-house' in the body against whom the complaint arises, overseen by a senior officer who has sufficient authority to resolve problems and who reports to board level; and the other an external ombudsman, who also has sufficient powers to investigate and require information from the target body, and has senior contacts within that organisation to raise issues.

   Within the UK although in-house customer care/complaint departments and the external ombudsman function exist with reasonable coverage, there is no uniformity of approach, so people do not think "if I have a problem I know who to go to". The system and its signposting need to be very simple, uniform across public and private sectors (the new EU legislation offers an opportunity to achieve this if, and only if, suitable architectural reforms are made). Being able to access the PHSO only through MPs is an unjustifiable impediment, since it introduces an unnecessary and potentially variable layer of bureaucracy.

   Why is there such potential duplication between appeals to Tribunals and the ombudsman? The vast majority of complaints do not require the decision-maker to decide a point of law. So they ought not to involve lengthy or costly procedures. Some private sector ombudsmen are now resolving significant numbers of cases within 48 hours; the maximum target under the ERU consumer legislation is 3 months; some cases take longer than others to investigate in the public sector, the current PHSO timescales are too long (and it is not her fault). Could we not save a great deal of money by simplifying the Tribunal complaint procedures, and switching many into the ombudsman track, since that ought to be more efficient and quicker? These considerations would, however, raise the question of whether the trigger of maladministration is remains relevant for every type of complaint: we think not.

3. **Using the information from complaints to improve behaviour.** This requires capturing all complaints from all sources, aggregating the information, looking at it critically, and drawing it to the attention of the right people, namely the public, senior management of the target bodies, and supervisory bodies, such as Parliament. These are classic functions of private sector ombudsmen and regulators. In the public sector, the PHSO is achieving a great deal here, but could be empowered to do more. It is important that *all* data has to be aggregated, from all sources (in-house, MPs, PHSO, other). Why should the PHSO not be able to initiate investigations, as many other public ombudsmen are in other countries?

4. **Managing and overseeing change. It** is not enough merely to report serious concerns about complaints. Someone with sufficient oversight power has to be overseeing that change (and the right change) is actually implemented. The private

sector brings about change using a three-tiered approach: firstly, in-house senior managers are apprised of the incontrovertible complaint evidence and concerns, and are empowered to be able to do something about it, especially if spurred on by, secondly, external public scrutiny and, thirdly, an external regulatory body.

This approach means that the data has to be collated and used, routed to the right people and made public, but there also needs to be oversight of the fact that change is implemented and exactly what change is made, to make sure it resolves the problem. We do not see that the oversight mechanisms, akin to the function and power of private sector regulators, exist in the public sector. There is a black hole here, which is seriously holding back the achievement of improving quality and avoiding problems like Mid-Staffordshire. In government departments, for exan1ple, who guards the guardians? Are Parliamentary Committees adequate or appropriate in overseeing change? Should a Cabinet Office oversight body exist? Should this be the function of the PHSO?

May 2013

Written evidence submitted by Local Government Association (LGA) (COM 09)

About the LGA

The Local Government Association (LGA) is the national voice of local government. We work with councils to support, promote and improve local government. We are a politically-led, cross party organisation which works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

Summary

Local government has well established complaints procedures. These include both procedures within an authority and through the Local Government Ombudsman (two people formally have the title of Local Government Ombudsman, each with agreed responsibilities and both sharing a support organisation).

Within a council there are both general complaints mechanisms and some service specific mechanisms, some of which have statutory underpinning. For instance planning appeals are subject to quite formal processes, and indeed we understand that Government is presently considering changes to that specific process. Similarly the process for appeals concerning schools admissions and complaints with regards to adult and children's social care, have statutory underpinning. As different tiers of authorities have different levels of responsibilities there is no uniform mechanism operating in every authority.

However, to illustrate the complexity of complaints arrangements, one London Borough has, in addition to a general complaints service, specific procedures for:

- Adult social care
- Children's social care
- Schools
- Code of conduct breaches by councillors or co-optees
- Disputed parking fines
- Planning decisions
- Complaints about council staff

In addition to the formal processes adopted by the council, the majority of councillors also provide some surgery service, at a minimum dealing with queries and complaints from constituents.

1. **What objectives should Ministers adopt when considering how complaints about Government and about public services provided by Government are handled? What gaps in the complaints systems exist; and how should ministers ensure they are addressed?**

1.1. From the local government perspective the problem is not one of identifying gaps in the complaints system. Instead problems arise because of overlapping mechanisms for complaint. These both unnecessarily duplicate processes and can be confusing for the people they are designed to assist in their complaints.

2. How effectively do Government departments and public service providers use complaints to improve the service provided?

2.1. Councils adopt two key principles in addressing complaints. First the initial proposed resolution level should be as localised as possible. This approach allows the quickest mechanism and means if the complaint has substance the issue can be tackled as quickly as possible. Such a mechanism is also easiest for an individual, as it does not require that person to be the legal expert (rather their expertise is their experience). Secondly, complaints should be part of the learning and improvement process for the authority.

2.2. However the use of the phrase “complaints” itself supposes a potentially confrontational situation. Many councils have encouraged feedback mechanisms, so that people can help councils both in defining priorities, and in improving the quality of service offered. Such an approach not only helps improve the quality of service, it also improves the confidence and trust of people in those services. The value of this approach is demonstrated in the continued improvement in trust and satisfaction in local government. This is in marked contrast with public perceptions of many other public services, including central government.

2.3. We are not therefore suggesting that local authority complaints procedures need to be more formalised, because that very formalisation would reduce the potential for innovation.

2.4. Local government has one key advantage over many other parts of public service provision, which is the democratic process. One of the concerns raised by local people is transparency. Local democracy provides two key opportunities for those people. First councillors have a local focus, representing the residents in their ward or division. They are therefore well placed to take up local issues, or issues where there are unintended consequences of a more general decision. Secondly, local politics is contested space. There are comparatively few authorities where there has not been some change of control. Active opposition, and the potential for change of control, again provides people with opportunities to ensure their voice is heard.

3. How quickly do complaints systems deal with legitimate grievances and provide redress?

3.1. Local authorities publish information on the numbers of complaints, as well as the outcomes. Our aspiration is always to seek to resolve issues locally and quickly;

however it is important to recognise that some complaints will not be resolved to the satisfaction of the complainant.

3.2. Given the continued restraints on local budgets councils are being forced to make difficult decisions about priorities. This means that the services that the complainant aspires to receive may not be always be available. We therefore need to focus not just on the technical speed of the complaint system, but also how well the system has been able to engage with the complainant. We can then judge whether they better understand the reasons for the decisions, even if they do not necessarily accept the reasons for that decision.

4. How easy is it to make a complaint about a Government department or agency, and how could this be improved?

4.1. No public body should ever be complacent about its process, and should always seek further improvements. An advantage of the nature of local government is that it has been able to be innovative and flexible in the evolution of its complaints procedures.

4.2. Authorities are also able to adapt to reflect local concerns. We have already illustrated one (inner) London authority with a discrete complaints procedure for parking tickets. This reflects the much greater amount of parking controls and congestion in inner London, leading to a very different level of work compared to most rural areas, or indeed many suburban areas.

4.3. Local government is a major funder of the Citizens Advice Bureaux and other independent advice agencies, which seek to help people find their way around the system. More generally local authorities are major funders of the voluntary sector. Very many voluntary organisations undertake advocacy as well as service delivery. A plurality of locally based advice and advocacy better serves people than remote centralised and silo based procedures. This funding of voluntary organisations is particularly important in providing support to vulnerable, disengaged or excluded groups, for example a local Age Concern is more likely to connect with vulnerable older people than any national service.

4.4. It is vital that public services learn from complaints. One of the major changes in local government democracy has been the roll out of scrutiny panels in councils, in part as a balance to the executive, but also to secure focus on outcomes and not outputs. As with the select committee structure in parliament not every scrutiny process was initially successful. However, no one now doubts the value of the parliamentary select committee process in driving improvements in public service.

4.5. The first authorities to establish scrutiny committees did so in the mid 1990s, with the wider roll out happening a decade ago. However, there is now evidence of the impact of the scrutiny process, with councils listening to experiences of users to help shape improvements in the way services are delivered. This process is extending, so

that increasingly there is scrutiny not only of local government services, but of local public services more generally.

5. Do complaints-handling systems achieve the right balance between nonjudicial and judicial investigations and remedies?

5.1. As outlined above, local government seeks to resolve complaints as locally as possible. Indeed we could describe the process as one of seeking pre-complaint solution; that is when the individual expresses concerns these should be properly considered, without requiring that person to enter a formal complaints process. Councillors' surgeries are an illustration of where most cases do not become formal complaints.

5.2. Following a surgery a councillor may act as an advocate, asking for a review or clarification. Often this intervention might not lead to a different outcome. For instance in many areas social housing allocation decisions may not change post the intervention, because the initial decision results from severe general housing pressure. However the individual seeking review has received independent confirmation of the fairness of the original decision.

5.3. Some processes tend to be more judicial than others, for example planning appeals and child custody cases. However as a general principle we would advocate a presumption towards informal redress.

6. How aware are service users of the various ombudsmen (such as the Local Government Ombudsman, Financial Ombudsman and the Housing Ombudsman)?

6.1. We believe the plethora of ombudsmen is confusing for people. Most people are not aware which ombudsman is responsible for what. Moreover the responsibilities of the Ombudsmen often overlap, and it can be unclear to a complainant which route they should pursue.

6.2. Our Whole Place Community Budgets work has shown just how many agencies can be involved in some people's lives. The troubled families work in particular has demonstrated that we need to look to new local configurations if we are to properly meet people's needs.

6.3. Many of the complaints procedures operate within those very silos that we need to change. There are cases of maladministration that are simply unacceptable. However, often the complaint is about the fact that a decision, taken within one part of the public sector system, failed to take account of a different set of circumstances which are the responsibility of a totally different part of the public sector.

May 2013

Walsall Council – Addendum

The council's complaints procedures

The council has defined a complaint as an expression of dissatisfaction with the council, its services or the actions of its staff. Most complaints fall into three main areas:

1. We may have failed to do something that we should have done.

2. We may have performed a service badly.

3. We may have treated a customer badly, or discourteously.

The council takes the view that someone informing us that something is not working (say, a street light) or is a neighbourhood problem (say, an overgrowing tree, or a noisy neighbour) is requesting the council to do something and not making a complaint. The council has other arrangements for citizens and users of our services so that they can report things like these, and ask for action to be taken. However, quite clearly, if that person has to contact the council again because nothing has been done to repair the street light or to prune the tree, or because the action taken was ineffective, or slow, then that is a complaint.

The complaints procedure has been developed to deal with complaints from local residents and other users of our services about the council, its services and the actions of its staff. It does not cover complaints about elected councillors or complaints from council employees about their treatment by the council as an employee. There are other procedures for these circumstances.

Anyone not satisfied with the council, its services or the actions of its staff can let us know by filling in the contact form for general enquiries, requests for services, complaints or compliments to be found on the council web site, or by completing the Tell Us leaflet (attached) and returning it to any council service point, or by making a complaint to a member of staff by the phone (which should be recorded in writing). Complaints, whether or not submitted via the Tell Us leaflet or contact form, or in other ways should be logged on the Tell Us system and sent to the relevant complaints directorate coordinator. The form is designed to obtain the following information:

- The complainant's name and address
- Contact details
- As much detail as possible about what happened, when and where and including the names of anyone involved
- Whether the matter has been raised with the council before?
- The name of any member of staff they have dealt with, giving dates, if possible
- That they agree with the use of the information they have provided

Emphasis is placed upon services seeking to address a resident or service user's concerns promptly, and without formality, before entering the formal complaint process. However, for complaints which cannot be dealt with in this way, where the resident or service user remains dissatisfied, the procedure has the following stages:

Stage 1
As noted above, complaints can be made in a variety of ways, and submitted to any council service point. Complaints will be registered on the Tellus system, and forwarded, electronically where possible, to the relevant directorate complaints coordinator. Complaints should be acknowledged within five working days, and after investigation by the service a full response should be provided within a further 15 working days. In cases where investigations need to be prolonged – for example, because of staff absence, or the complexity of the matter in question – the complainant should be advised of any delay.

Stage 2
If the complainant is dissatisfied with the response, they can ask for the complaint to be considered by a senior manager in the service concerned.

Stage 3
If the complainant remains dissatisfied, they should be advised that they may, in most circumstances, refer their complaint to the Local Government Ombudsman, who is independent of the council. Details about the Ombudsman are included in the council's own complaints leaflet and on the council web site.

Please note: there are separate, related, procedures for complaints about social services provided by Adult Services and Children's Services, established in line with legislation including the Children Act 1989 and the NHS & Community Care Act 1990.

Written evidence submitted by from Citizens Advice Scotland (COM 10)

- Citizens Advice Scotland and its member bureaux form Scotland's largest independent advice network. CAB advice services are delivered using service points throughout Scotland, from the islands to city centres.
- Citizens advice bureaux in Scotland helped clients with over 500,000 new issues in 2011/12 – more than 1,400 new issues for every day of the year. Nearly 200,000 clients brought new issues to a bureau over the year.
- In 2011/12, Scottish bureaux achieved a financial gain of almost £140million for clients based on funding of £16.9million.

Citizens Advice Scotland welcomes the opportunity to respond to the Public Administration Select Committee's inquiry into the complaints process for public services. The biggest area of advice provided by citizens advice bureaux in Scotland relates to benefits and tax credits. Our response to the select committee focuses on issues relating to these.

Context

In 2012/13, citizens advice bureaux in Scotland advised on nearly 319,000 benefits issues. Over 116,000 of these benefits issues were repeat issues, where the client was coming back with further issues regarding the same benefit. These may be cases where someone has previously come into a bureau for help with an application, and, for example, returns to sort out a change of circumstances or take forward an appeal following an adverse decision. But often people come in for basic problems such as finding that their benefit payment has ceased without notice, leaving them with no income.

Over the five years to 2011/12, the number of benefits issues seen in bureaux has increased by 39%. Employment and Support Allowance (ESA) is a significant driver of advice demand, with the number of sickness/disability issues increasing by 55% over the four years since the introduction of ESA. Other drivers of demand include increasing referrals from Jobcentres to bureaux, the inaccessibility of DWP and HMRC phone lines and the drive towards moving benefit claims online.

We are also supporting many more people at appeal. Between 2009/10 and 2011/12 the number of benefit tribunals where bureaux represented clients increased by 118%. We have seen a 78% increase in the number of cases we support but cannot represent in the last five years.

Many of the clients who come to bureaux with problems with benefits have difficulties negotiating the administration of the benefits system, which can lead to substantial difficulties. In 2011 the Trussell Trust, the biggest food bank provider in Scotland, found that the biggest driver of demand for food parcels was problems with the benefits system Almost half (48%) of all referrals to the Trust were generated by delays in payments and changes in

entitlement. Since then the Trussell Trust have seen a 150% increase in the number of people in Scotland using foodbanks.

There has recently been a huge increase in the number and duration of sanctions applied to benefits, and bureaux across Scotland are seeing clients in hardship as a result. Many of these sanctions are applied inappropriately, and sometimes in circumstances over which the client has no control.

The following cases give examples of the quality of benefits administration bureaux regularly see:

An east of Scotland CAB *reports that a client has had her JSA sanctioned for 6 weeks for failing to attend a Life Skills interview. JobCentre Plus has now admitted that they sent the letter to the wrong address. There is often confusion with her property called "--- Cottage" at no.21 and a couple of doors up called "--- House". The client has had no money for 5 weeks. She is diabetic and lives on her own. The local Jobcentre have not been helpful (apart from one person finally), and the client is distressed by her inability to get someone to take responsibility and to get her the money due. She tried for a Crisis Loan but was rejected because she has been sanctioned. Once her sanction expires she has been told she will not receive any money for a further two weeks. The client is in dire straits financially. She has not been informed of the option to apply for Hardship Payments.*

A west of Scotland CAB reports *of a client who moved from elsewhere in Scotland to this area on the 7th of the month. She received her last JSA payment on the 2nd. When she arrived in this area she signed on for JSA at the Jobcentre on the 13th. However she has heard nothing regarding her claim. She completed a new claim on the 23rd, still with no result. Finally she completed her third JSA application on the 6th of the following month After this, the client came to the bureau and asked them to contact the Jobcentre regarding this on her behalf. The adviser contacted the Jobcentre office but was informed that there was no record of any claims made by the client for JSA. It was suggested that the applications were lost either in the mail or the system.*

An east of Scotland CAB reports *that a client presented at the bureau, having been sanctioned from JSA after breaking his Jobseekers agreement. The client stated that he had not been fully engaged in looking for work because his three month old son is seriously ill and he was at his bedside in hospital following kidney failure. As a result of the sanction the client had no money for food and wanted to know what help was available. His 10 year old daughter stays with him at weekends. The client was referred to the Crisis Food Bank. It would appear that no account was taken of the extenuating circumstances that this client found himself in when he was sanctioned. The CAB state that there are clear guidelines about the use of discretion when decision makers opt for sanctions but in this case they appear to have been ignored.*

An east of Scotland CAB reports *a client who has a joint claim for Jobseekers Allowance with his fiancée. He has previously worked as a scaffolder and completed 'Part 1' training and is desperate to return to paid work. He is aware that a scaffolding company are recruiting around 100 scaffolders to work on the decommissioning of a local power station. He has sourced training (Part 2 scaffolding and health & safety) and his family have paid for the training costs. He informed the local Jobcentre, as the training lasts 10 days and is based in England, meaning he would miss two signing-on days. The Jobcentre told him that he is only allowed one 'exclusion' and he cannot miss two signing-on days or he will be sanctioned and benefit payments stopped indefinitely. The client cannot risk going with no money for an indefinite period of time, especially as it would affect not just himself, but his fiancée, her two children and possibly their as-yet unborn baby. He feels staff at JCP were unhelpful and obstructive and preventing him from doing something which would greatly increase his chances of getting paid work. He feels he now has no option other than to cancel training (and very possibly lose the money paid) so that his benefit is not stopped. This will also reduce his chances of getting a job.*

Use of complaints procedures
Despite a system which is clearly not working effectively, the number of complaints issues recorded by bureaux is relatively small: in April 2013, of the 22,486 issues reported about benefits and tax credits, only 193 issues related to poor administration and/or complaints regarding DWP-administered benefits, and 46 for HMRC administered tax credits. The benefit with the highest proportion of issues with poor administration and/or complaints was Jobseekers Allowance, making up 3% of all JSA issues. This is followed by ESA (1.7%) and then Working Tax Credit (1.4%), and Child Tax Credit (1.2%).

Reasons for not using complaints procedures
There are a number of reasons why bureaux and their clients may not use the complaints mechanisms available to them.

Apart from the complaints procedure, there is a clear route to resolving issues with benefits through the review and appeals processes. There are clear process requirements in these, including timeframes and requirements for DWP to justify their decisions. The appeals process is independent, which means this tends to be an effective route for resolving issues.

Our experience is that getting resolution with tax credits issues is much more difficult, partly as a result of a lack of an independent mechanism.

Limited capability to take forward complaints
People who use Citizens Advice services are often in vulnerable circumstances and may have limited capability to resolve issues or take complaints themselves. They may have limited or no access to the internet, limited or no access to the phone, and sometimes have no money for travel or postage. They may also have ill health, including mental health issues or learning disabilities. Increasingly we are seeing people who are destitute, having not eaten for several days. For these people their priority is to resolve problems with benefits so that they can get the money they need to feed themselves and their families, heat their homes and pay for other basic living costs. Making a complaint becomes a much lower priority when people are struggling to meet basic survival needs.

Getting initial resolution of an issue is arduous
Anecdotally, bureau advisers report that it frequently takes 20 minutes on hold to get through to Jobcentre Plus to resolve issues, but in some cases can take two or three hours. These phone numbers are often charged at business rates, which is costly, especially for clients calling from mobile phones. Security checks appear to be increasingly difficult for clients to pass, and clients are regularly failing the maximum of three times, requiring 60 minutes of hold time for three phone calls. Once the client and adviser are able to get through they may be passed between numerous sections of the relevant department, before they can make progress.

A North of Scotland CAB reports *that following the client's online application for Jobseekers Allowance he was told that he would be informed within 24 hours of his interview date and time. He has not yet received this information. The client has no money and no food and is diabetic. We phoned the DWP to try to find out how long it might be before the client received his first benefit payment so that a reasonable estimate of need could be made for the Short Term Benefit Advance (STBA).*

- *Phone call 1 (10 mins on hold): Client failed security check.*
- *Phone call 2 (10 mins on hold): Client again failed security check. The client was repeating information which has never previously failed a security test in this adviser's presence. We were advised to phone a third time and that if that call also failed security we would need to request a call back from DWP to the client's home number and that this would take place about 1600 hours, at which point the client would no longer be in the office.*
- *Phone call 3 (10 minute on hold): We were informed that as a CAB we could request an "Implicit Consent" which would bypass this process. Implicit consent was granted. In response to our query concerning the delay in setting up an interview we were directed to the new claims line.*
- *Phone call 4: Called new claims line. Redirected to the "Queries being processed line".*
- *Phone call 5 (10 minutes): They checked their records which showed that the client's application had not been registered yet. We were directed back to the New Claims line (10 minutes).*
- *Phone call 6 (10 minutes): The New Claims line set up an interview for the client. New Claims also informed us that normally the client could not make a claim for a Short Term Benefit Advance until he had signed on at his initial interview. They agreed to try to process an STBA immediately but this meant that the client would be phoned for an interview at 1600 hours on Friday and had no hope of money until next week.*
- *Phone call 7: Telephoned Social Services who agreed to see the client at 1400 hours in their office to see if he might be eligible for a food parcel.*

An east of Scotland CAB *reports of a client who has mental health problems & so has a Penumbra Support Worker and a Community Psychiatric Nurse. He has received a letter from Bathgate Benefit Centre (dated five days previously) requesting his telephone number so that they can call him regarding conversion from Incapacity Benefit/Severe Disablement Allowance/Income Support on the grounds of illness or disability to ESA. The letter states the call must be made within seven days. His Support Worker tried calling the Benefit Centre with the information but couldn't get through. The call used all £6.20 of the client's phone credit. The client was finding the situation stressful and as he has no more phone credit he asked the CAB to make the call on his behalf. The CAB agreed to call on his behalf to pass on the number and explain he needs a Support Worker to help him deal with the agency. The adviser called the Benefit Centre number on the client's letter and got a recorded message 'Service unavailable'. The adviser then called Escalation Route 1 phone line several times - always engaged. Then the adviser called Escalation Route 2 phone line several times – also always engaged. The adviser then wrote letter to the Benefits Agency on the client's behalf as a back-up to calling. Client will post the letter and return to the CAB tomorrow for another adviser to try phoning on his behalf. The adviser reassured the client that he is doing all in his power to comply and that the CAB would be able to confirm this if necessary.*

When the system is so poor that resolving very simple problems, such as getting a form sent to the client, can be incredibly difficult, people are often relieved just to be able to resolve their immediate problem. Given their experience, pursuing a complaint may not be a priority, or they may not have faith in the organisation's complaints process, or feel that making a complaint is unlikely to have much impact.

Similarly, the length of time it takes to resolve an issue for a client, combined with the huge increase in benefits issues that bureaux are having to deal with, means that many bureaux are operating at capacity. In many cases this means that taking forward a complaint, which may in itself take some time with limited outcome for the client is not a priority in the face of so much need.

Clients may be fearful of making a complaint

Clients may be afraid that making a complaint will affect their benefits. There has been a massive ramping up in the application of sanctions to means-tested benefits in the last few months. We have seen many cases where the sanctions applied seem arbitrary or unfair.

Other factors

The political and media rhetoric around benefits claimants is particularly negative at present. The inaccurate use of statistics by government ministers[1] and discussions of "work-shy" benefits claimants[2] are two very recent examples. In such a climate benefits claimants may be more reluctant to take forward complaints, even where handling of claims and treatment of the claimant are very poor.

Problems with Government-contracted services

One issue that has been growing recently is problems with Government-contracted Work Programme providers. Poor administration by them is leading to the sanctioning of claimants' benefits. Even when challenged the sanctions are being upheld by the Jobcentre. DWP has told us that claimants must use the Work Providers complaint process to tackle these issues. We do not consider this a satisfactory response. A complaints process is not sufficient recourse where someone has lost their income stream for weeks at a time.

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[1] http://www.statisticsauthority.gov.uk/reports---correspondence/correspondence/work-programme-statistics.pdf

[2] http://www.dailymail.co.uk/news/article-2319355/Workshy-map-Britain-revealed-Thousands-incapacity-benefit-claimants-capable-working.html?ito=feeds-newsxml

A West of Scotland CAB *reports of a client who has had his JSA sanctioned. The sanction came after the client had received several pieces of correspondence from the Work Programme provider with no postage paid. On one occasion it cost him £5.50 to go to the sorting office and get the letter cleared. He informed the provider of this and told them he couldn't keep paying to get their letters. The next time it happened he refused to collect the letter and so was sanctioned. He was not informed about the sanction until he found the money had not been received. He asked for a reconsideration, providing evidence from the Royal Mail, but the DWP have not changed their original decision.*

A South of Scotland CAB *reports of a client who is on JSA but has been sanctioned for non-appearance at an appointment made for her by Ingeus on 27 September. The client said she had not been informed about it either by letter, email, phone or text message. In the sanction letter she has received from DWP it seems Ingeus told them that she had been informed on 23 September. The client did not know anything about this until she received a letter from her personal adviser at Ingeus giving her an appointment on 3 October which the client had to move to 5 October because of a prior appointment. It was only now that the client became aware of the appointment on 27 September when the personal adviser spoke about sanctions. This bureau regularly sees clients who have been sanctioned for missing appointments, despite the client not receiving any notice of them.*

Raising issues directly with DWP

Because of the volume and severity of issues faced by citizens advice bureaux across Scotland, CAS has developed a dialogue with DWP about these issues. While this is at relatively early stages, and we are hopeful that our engagement will become increasingly constructive, our initial experience has been that the process of engagement has been slow, and the unfairness and seriousness of the impact of clients resulting from the problems raised has not been recognised.

Conclusion

Bureaux experience very significant difficulties resolving problems with benefits and tax credits on behalf of clients. A complaints mechanism is only as good as the system it supports. Where there is a lack of faith in the system itself, it is likely there will also be a lack of faith in the complaints procedure. The low number of complaints about benefits seen by CAS as compared with the large volume of appeals suggests that this may be the case for the complaints mechanisms for DWP benefits and HMRC tax credits.

May 2013

Written evidence submitted by Administrative Justice and Tribunals Council (COM 11)

Introduction

The AJTC submits this evidence to assist this PASC Inquiry, which will consider whether the current complaints system delivers fairness, redress and justice for people who complain; and examine how departments and agencies use complaints as a source of information and challenge, so as to improve the delivery of public services.

The AJTC very much welcomes this Inquiry which represents the next stage in PASC's work on this issue, following on from its previous report '*When Citizens Complain*' (Session 2007/08, HC 409). That referred back in turn to the NAO report on Citizens' Redress in 2005,[1] which was described by the NAO as a "first attempt to sketch the overall picture".[2] It is regrettable that the NAO report did not attract much attention at the time and has not led to much governmental follow-up since.[3]

It has been suggested that (at least some) private sector organisations discovered many years ago that good complaint-handling serves three distinctive, but over-lapping, purposes:

1. to provide an avenue for redress (e.g. refund, compensation, replacement or apology) for aggrieved individuals;
2. to enable aggrieved individuals to report or share their experience, so that others do not suffer in the same way;
3. to enable the supplier to obtain feedback about grievances as vital market intelligence ("cheap market research"), both to improve things and to build and reinforce customer loyalty.

Without competitive pressures, it would seem that much of the public sector has failed to adopt such a positive approach. Complaints are generally unwelcome or resisted; and, with honourable exceptions, redress is provided begrudgingly. Perhaps

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[1] http://www.nao.org.uk/report/citizen-redress-what-citizens-can-do-if-things-go-wrong-with-public-services

[2] *Ibid.*, Preface, paragraph 2

[3] It should be noted that there has also been significant work undertaken on the subject in Scotland. In 2007 the independent review of the regulation, audit, and inspection of complaints handling for public services in Scotland (headed by Professor Lorne Crerar) reported to the Scottish Government: http://www.scotland.gov.uk/Resource/Doc/198627/0053093.pdf/
In light of that review, the Scottish Government then went on to establish focus groups to consider the report's recommendations. One of these, the 'Fit for Purpose Complaints System Action Group' (chaired by Douglas Sinclair) reported to Ministers in 2008 on proposals for making complaints handling - and especially in the social care sector - more responsive, consumer-centred, and less bureaucratic: http://www.scotland.gov.uk/Resource/Doc/923/0063564.doc

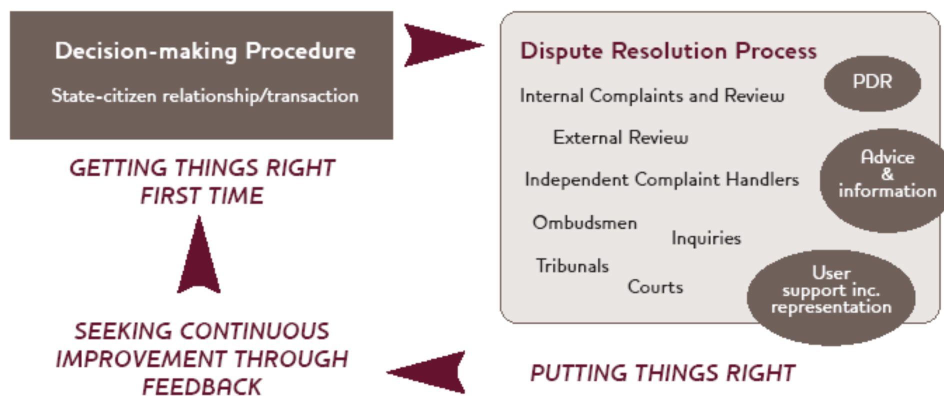
most importantly, there is also far too little by way of learning from complaints and appeals to improve the delivery of public services.

The AJTC suggests that there is considerable scope for improving the quality of public services, and reducing overall costs, by taking grievances and complaints more seriously. Equally, a more enlightened approach, with emphasis on the "human touch" rather than the "faceless bureaucracy" which many believe to exist, would do much to improve the reputation of public administration and relationships between citizens and the state.

Complaints and the administrative justice system

As we have described in previous evidence to the Committee,[4] the AJTC regards complaints schemes as part of the wider administrative justice system, typically operating where there have been mistakes, misunderstandings or unacceptable standards of service. The administrative justice system as a whole also includes the arrangements available for questioning, challenging and/or seeking to change the decisions of public bodies, which may also have been mistaken or founded on a misunderstanding. It is a system which covers internal complaint schemes, third-party or external reviewers, ombudsmen, tribunals and the Administrative Court.

The AJTC produced this model to illustrate the links between the various stages of the administrative justice system. The model sets complaints and other dispute resolution schemes into their broader context:



In a recent AJTC publication,[5] which looked at proportionate dispute resolution across public services, we concluded that the current approach to resolving administrative justice disputes is not sufficiently sophisticated to address the varied and complex nature of grievances. These grievances tend to be categorised as either an appeal against a decision, or a complaint about service. Two largely separate paths to

[4] Evidence to PASC Inquiry - 'The future oversight of administrative justice: the proposed abolition of the Administrative Justice & Tribunals Council', November 2011
[5] 'Putting it Right: a strategic approach to resolving administrative justice disputes', June 2012: http://ajtc.justice.gov.uk/docs/putting-it-right.pdf

redress have been built on the basis of this distinction, with most appeals being determined by tribunals and most complaints handled internally or by ombudsmen as a last resort. The difficulty with this approach is that aggrieved individuals can often find it difficult to isolate the separate elements of their grievance – for example, they may wish to complain and appeal or may not actually be clear about what (specifically) they want to challenge. The technical distinction between complaints and appeals is not always obvious either, especially to users. Complicating matters even further is that they may not know which institution they should turn to in order to make their challenge, and the links between the different institutions are not always sufficiently strong to ensure that cases are transferred to the correct channel.

It should also be noted that neither the complaints system, nor the wider administrative justice system, is integrated or uniform across the UK. For example, the Parliamentary Ombudsman functions at a UK level in respect of government departments (whilst enjoying an additional distinct role as Health Services Ombudsman for England), while the Scottish Public Services Ombudsman, the Public Services Ombudsman for Wales, the Northern Ireland Ombudsman and the Local Government Ombudsman (for England) all function individually within their respective territories, but with some differences of approach and jurisdiction.

Complaints: the questions posed by the Inquiry

The Issues and Questions Paper on complaints handling published by PASC poses ten questions for consultees. Of these, the following questions are those which the AJTC considers it can best assist the Committee:

What objectives should Ministers adopt when considering how complaints about Government and about public services provided by Government are handled?

In November 2010 the AJTC published a paper setting out its '*Principles for Administrative Justice*'.[6] These were directed towards both initial government decision-making and subsequent redress mechanisms, whilst being aimed at organisations and individuals who either deliver or commentate on administrative justice. The Principles built on previous work in the field, and in particular on the Parliamentary and Health Service Ombudsman's '*Principles of Good Administration*'.[7] The AJTC Principles stated that a good administrative justice system should:

1. make users and their needs central, treating them with fairness and respect at all times;

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[6] http://ajtc.justice.gov.uk/docs/principles_web.pdf

[7] http://www.ombudsman.org.uk/__data/assets/pdf_file/0013/1039/0188-Principles-of-Good-Administration-bookletweb.pdf; as supplemented by the '*Principles of Good Complaint Handling*': http://www.ombudsman.org.uk/__data/assets/pdf_file/0005/1040/0188-Principles-of-Good-Complaint-Handling-bookletweb.pdf

2. enable people to challenge decisions and seek redress, using procedures that are independent, open and appropriate for the matter involved;
3. keep people fully informed and empower them to resolve problems as quickly and comprehensively as possible;
4. lead to well-reasoned, lawful and timely outcomes;
5. be coherent and consistent;
6. work proportionately and efficiently;
7. adopt the highest standards of behaviour, seek to learn from experience and continuously improve.

The paper sets out the thinking behind these principles and in the AJTC's view they should inform how government sets objectives concerning complaint handling. It is clearly in the public interest to seek to resolve disputes as quickly as possible, given that protracted disputes between citizen and state become expensive, more difficult to resolve, and contribute to the depletion of resources. Government objectives should be focused on the early resolution of disputes, a "Horses for Courses" approach to ensure that the most appropriate resolution technique is being applied, and continuous learning to promote a "Right First Time" culture in which complaints and disputes are minimised.

How effectively do Government departments and public service providers use complaints to improve the service provided?

There is clearly substantial scope for government to use information from complaints and successful appeals to improve the quality of services. There is also scope for complaint-handling schemes to feed back information in ways which are constructive, meaningful and likely to be actioned. Unfortunately, the PHSO has previously described complaints handling across government as "inconsistent, haphazard and unaccountable, operating without any overarching design, overall standards, or performance framework".[8] PASC itself has previously said that it:

> "regards the high level of successful appeals and complaints against decisions by government departments as an indication of widespread administrative failure. Government should aim to produce decisions which are right first time and command a high degree of confidence. The scale of the injustice and the cost to the taxpayer by this decision making are wholly unacceptable".[9]

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[8] '*Responsive and Accountable*? The Ombudsman's review into complaint handling by government departments and public bodies 2010-11', Session 2010-12, HC 1551, at page 2

[9] 'Future oversight of administrative justice: the proposed abolition of the Administrative Justice and Tribunals Council', Session 2012/12, HC 1621

A crucial problem is that accountability within government for leadership and governance of the complaints systems is currently not clear. The Ministry of Justice has stated that it is it is well placed to undertake the oversight of the administrative justice system across the UK and that it:

> "works closely with the Cabinet Office on ombudsman policy, and…collaboratively with the Parliamentary and Health Service Ombudsman. Whilst maintaining the independence of the ombudsmen these interactions enable the Department to be in a good position to raise the profile of other public service ombudsman across Whitehall. The Department also works closely with the devolved administrations to develop an overview of the wider system across the UK, sharing best practice and ensuring appropriate consistency in the rules and processes".[10]

However the recently published Ministry of Justice '*Administrative Justice and Tribunals: A Strategic Work Programme*'[11] does not focus on complaints issues in any detail at all and is largely focused on tribunals. While the Cabinet Office has responsibility for ombudsmen, it does not seek or exercise a responsibility for complaints policy generally. It is noteworthy that its current work on 'Fraud and Error' seems predominantly concerned with the fraud and errors of claimants rather than with the mistakes of government departments in the assessment of claims.[12]

Who should be accountable for leadership and governance of complaints systems across government and its agencies?

It is fundamental that there should be clarity about the status and role of each element. In particular, as the AJTC Principles make clear, independence is vital for the credibility of external dispute-resolution bodies (such as ombudsmen). This will normally mean independence from the organisation (e.g. a government department or local authority) generating the grievances. The constitutional arrangements are the primary safeguard of independence, but effective corporate governance is also needed to ensure operational independence in practice and the delivery of timely and efficient results.

What do complaints cost?

The AJTC is aware that information about the costs of schemes is highly fragmented. Although the overall cost of each scheme is usually available, there is no central

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[10] MoJ evidence to PASC enquiry on the proposed abolition of the AJTC, para. 4

[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/162270/admin-justice-tribs-strategic-work-programme.pdf.pdf

[12] See, for example, the report of the Fraud and Error Taskforce (February 2011): http://old.cabinetoffice.gov.uk/sites/default/files/resources/HMG-Fraud-and-Error-Report-Feb-2011-v35.pdf

collection point. Nor are statistical, performance, unit cost or other comparisons between the schemes easy. This is partly because of subject-matter (e.g. it is impossible to compare a complaint about unsuccessful brain surgery with a complaint about rudeness in a local Job Centre). But there is also a general lack of definitional agreement on terms such as "inquiry", "grievance", "complaint", "claim", "dispute", "appeal" etc.

The NAO report in 2005 established some figures for the likely cost of particular dispute resolution mechanisms. As of that time, it suggested that "redress operations of central government involve more than 9,300 staff and…cost at least £510 million per year to operate".[13]

How easy is it to make a complaint about a Government department or agency, and how could this be improved?

The AJTC held a workshop on good practice in complaints handling in the public and private sectors jointly with the Whitehall and Industry Group in April 2012. A note of that workshop is attached. The new approach towards complaints taken by the Department of Work and Pensions emerged as a model of good practice for the public sector.

More generally, important points which emerged from the workshop included the following:

- good communications and the human touch are vital - especially a positive attitude towards the use of the telephone;
- DWP no longer requires a written record to be kept of phone calls in all cases;
- usually complaints should be encouraged, not discouraged, and especially to obtain useful feedback;
- modern technology plays a vital part, especially if it brings all the records and documentation together in one place;
- private companies have to get complaints resolution right or eventually go out of business;
- the public sector does not have the same incentives;
- sub-contractors who face financial penalties in their contracts (as at DWP) are well incentivised to resolve complaints quickly and well – although it is equally important to acknowledge that such penalties can have distorting effects unless care is taken to avoid them.

Do complaints-handling systems achieve the right balance between non-judicial and judicial investigations and remedies?

[13] NAO report (no. 1), paragraph 2.27

Complaints handling systems such as internal complaints mechanisms and the work of ombudsmen do not use traditional judicial techniques. The reasons for this approach, and its benefits, were examined in some detail in the External Review of the Local Government Ombudsman which was led by the Chairman of the AJTC. Its report was published in April 2013.[14] Judicial techniques, but with a more informal and inquisitorial style, are used in tribunals; whilst the Administrative Court operates as a conventional court. The AJTC has made recommendations regarding the principles and factors that should be taken into account when deciding the most appropriate route to resolve a grievance.[15] The general factors to be considered are:

- the capacity of the parties to participate effectively;
- whether and how the parties are represented;
- the context of the case including the history of past disputes;
- any identified need for urgency;
- the nature, importance and complexity of the issues in dispute;
- the likelihood of an agreed outcome;
- the cost to the parties and to the tax payer.

The AJTC believes that there is considerable scope for experimentation with dispute resolution techniques and that there are opportunities to use ombudsman-type techniques in some cases currently subject to judicial processes (and especially through a more activist/interventionist approach to fact-finding and mediating between the parties, as ombudsmen methods tend to ensure).

How aware are service users of the various ombudsmen (such as the Local Government Ombudsman, Financial Ombudsman and the Housing Ombudsman)?

The challenge is perhaps more the lack of awareness about the demarcation lines between the different schemes (see above) and about what to expect within each scheme. The External Review of the Local Government Ombudsman concluded, for example, that the LGO faced considerable problems of communication and presentation and that it should do more to educate the public about its work and the approaches it adopts. The same is likely to be true of other schemes.

That having been said, a lack of public knowledge of the very existence and role of ombudsmen (as opposed to of the demarcation between the various schemes) is also reasonably common, although there are exceptions. The Financial Ombudsman, for

[14] http://www.lgo.org.uk/news/2013/apr/lgo-welcomes-independent-confirmation-fair-effective-ombudsman
Annex D of that report in particular examines how the LGO, and the Ombudsman institution in general, has become an essential and embedded feature of the administrative justice system. The Annex develops the point that an ombudsman is an investigator and dispute resolver, not an appellate body, and provides different procedures and remedies from those found in courts or tribunals.

[15] See paragraphs 125 – 134 of the AJTC's '*Putting it Right*' report (no. 5)

example, has gained very wide recognition, and not least because of its role in securing high profile compensation for mis-selling arrangements.

So far as ignorance exists, we suspect that it is only likely to be higher within social groups which tend to be further removed from the political system, such as ethnic minorities or residents of poorer communities.

How should complaints about complaints systems be handled?

In "*Putting it Right - a strategic approach to resolving administrative disputes*" (June 2012), the AJTC made a number of recommendations concerning improvements to complaint handling and tribunal systems. We recommended that the forthcoming (at that time) Ministry of Justice Strategy for Administrative Justice should "articulate and link the triple goals of improving citizen satisfaction with public services, tailoring redress mechanisms more closely to users' needs and significantly reducing public expenditure", and that the Ministry should go on to report to Parliament on its progress in implementing the Strategy. We were disappointed that the Strategy, when published, did not envisage the Department taking the lead across government in monitoring the performance of complaints handling systems as a whole; and neither did it envisage how that leadership role might be exercised by other bodies or agencies (whether in conjunction with the Ministry or otherwise).

The AJTC certainly believes that there should be a single point of contact for impartial information on where to make a complaint or to seek redress, although it is likely that separate arrangements will need to exist for Wales and Scotland, at least in respect of devolved functions. We note how PASC itself called for something of the kind in paragraph 42 of its '*When Citizens Complain*' report. The website Gov.UK is now seen as central to government's plans in this respect but the AJTC has concerns that a central government source of information about disputes between citizen and state cannot truly be seen to be impartial, in that there is always a risk that insufficient information would be provided, or else that any advice offered further to the information would be (or would be seen to be) incomplete, guarded or otherwise unhelpful.

On the specific point about "complaints about complaints systems", the AJTC favours an element of finality and is sceptical about additional complaint or appeal mechanisms. Best practice appears to lie with those schemes which have introduced an external reviewer to consider complaints about the service provided (as opposed to outcomes reached).

May 2013

Written evidence submitted by Which? (COM 12)

1. Introduction

1.1 Which? is an independent, not-for-profit consumer organisation with around one million members and is the largest consumer organisation in Europe. Which? is independent of Government and industry, and is funded through the sale of Which? consumer magazines, online services and books. Which?'s mission is to make individuals as powerful as the organisations they have to deal with in their daily lives by empowering them to make informed decisions and by campaigning to make people's lives fairer, simpler and safer. We work across a wide range of consumer markets including energy, personal finance and public services.

1.2 Which? research indicates that there are not only multiple barriers to people wanting to complain or give feedback about public services, but that public service providers and independent bodies must do more to facilitate feedback and ensure that more information is available about how to complain.

1.3 One of the main reasons people give for not complaining is the fact that they do not think anything will change as a result. All public service providers and regulators must provide greater clarity about how feedback will be passed on and registered at a regulatory level.

1.4 Further barriers exist in health and social care due to the complex nature of the 'complaints architecture'. Given the recent changes in primary care, the Government must monitor how local Healthwatch are proactively seeking feedback and relaying intelligence to national Healthwatch to help identify systemic problems. Local authorities should also ensure that independent complaints advocacy is available to those with complaints about social care services as well as health.

1.5 The Government should undertake work to look at how the intelligence provided by feedback sites, such as NHS Choices and Patient Opinion, can be pooled for easy review by the public and systematic review by commissioners and regulators.

1.6 The Government should ensure that lessons are learnt and applied from best practice in complaint handling in other industries, particularly financial services, as well as recent developments in the private sector to have greater consistency in the operation of Alternative Dispute Resolution (ADR) mechanisms across different sectors.

2. What objectives should Ministers adopt when considering how complaints about Government and about public services provided by Government are handled?

2.1 A complaints mechanism in any market serves a number of purposes; it should create a dialogue between an organisation and its customers that allows individuals to give feedback when they are dissatisfied with a product or service; resolve problems and provide appropriate redress; provide feedback to the provider to make improvements; and provide evidence at a systemic level for commissioners, regulators and government to take action.

2.2 These objectives apply to public services as much as private, consumer markets. Indeed having effective mechanisms to promote feedback is more important in public services given the 'relational' rather than 'transactional' relationship that consumers have with providers. Consumers may be less able or willing to switch provider than in a consumer market due to a personal relationship, for example with a GP, the upheaval involved in switching provider, for example a school or care home, or due to a lack of market choice. This makes feedback crucial in ensuring that public services are user-focused.

2.3 These objectives are equally important in public services delivered by private and voluntary organisations. Furthermore, where services are delivered at a local level or by a range of providers, rather than centrally or by a single provider, it is important that a consistent approach to complaints is taken. All consumers should have the same opportunity to give feedback and to access redress regardless of who is delivering the public service they are using.

2.4 If public service complaints systems are to be effective then steps must be taken to address the dissatisfaction that currently exists when complaints are resolved locally; the need for advocacy and effective mechanisms to encourage feedback; and to ensure consistent complaint collection and sharing of information between public sector bodies at a local and higher level are necessary to ensure that complaints play a role in driving improvements to services.

3. How easy is it to make a complaint about a Government department or agency, and how could this be improved?

3.1 Which? research suggests that fewer people complain about public services than private companies. Just 65% of those who had cause to complain about an NHS service in the last year did so, while 69% complained about another government service, such as the DVLA, the passport service or HMRC. By contrast, 90% of those with cause to complain about a high street retailer did so, 89% complained about a bank or tradesperson and 83% complained about an energy supplier.[1]

[1] Populus, on behalf of Which?, interviewed a random sample of 2,101 UK adults aged 18+ online between 3rd and 6th May 2013.

3.2 Of those who complain, perceived resolution of complaints at a local level is lower in public services. Almost six in ten people who complained to an NHS or Government service felt their complaint was not resolved at the initial stage in comparison to 42% for energy suppliers and banks and 30% for high street retailers.

3.3 Which? research indicates that there are multiple barriers to people wanting to complain or give feedback in public services, both in terms of the perceptions of users and the means by which providers publicise feedback and complaints mechanisms. Recent research found that the main reasons people give for not complaining to GPs are because they do not think anything will change (51%) or because they fear worse treatment as a result (27%). This research also identified smaller but significant barriers with some people stating that they did not know who to complain to (11%), did not know how to complain (13%) or felt that complaining was too difficult (11%).[2]

3.4 Qualitative research by Which? with users of social care services has found similar issues, in particular people fear that their complaints will result in worse treatment or defensive behaviour by care staff.[3]

3.5 Public service providers and independent bodies must do more to facilitate feedback from users and more information should be available on how to complain. A recent Which? survey of 1,001 GPs[4] found that only 53% publicised complaints procedures using leaflets or on their website. Many GP practices could do more to solicit feedback. While 66% have a suggestions box and 61% run their own survey, only 58% have patient involvement groups, which should exist at every practice.

3.6 Access to advocacy is also an important way to encourage feedback and ensure that everyone who has cause to complain has the opportunity to do so, particularly vulnerable groups. Under the new health system, local authorities have a duty to provide independent complaints advocacy services for health, which in the majority of cases will be commissioned from local Healthwatch bodies. If local Healthwatch bodies are to fulfil their mission as consumer champions effectively, they should proactively seek feedback from service users and ensure that information and advice on how to complain is made available

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[2] YouGov, on behalf of Which?, interviewed a random sample of 5,257 UK adults aged 18+ online between 9th and 13th July 2012.

[3] In January 2012, 30 older people or their carers kept diaries of their experiences of home care for Which?. The exercise was repeated in May and June 2012 with 45 family carers. Similar issues surfaced in a Which? online forum with 50 Which? members with experience of arranging care for themselves or for a relative in the last two years, conducted in April 2013.

[4] Medeconnect, on behalf of Which?, interviewed a representative sample of 1001 GPs across the UK online between 22nd and 31st August 2012. Data weighted to be representative of all GPs in the UK.

to those who need it. Local authorities should also ensure that this service is available to people with complaints about social care.

4. Do complaints systems succeed in making public services and Government departments more accountable and responsive to service users?

4.1 As the table[5] below demonstrates, the degree to which people feel that public services are responsive to their views varies, with people feeling that this is least the case in secondary health care and social care.

To what extent do you feel that your views are taken into account when using the following services?	Taken into account	Not taken into account
GP	41%	21%
Dentist	41%	21%
University	40%	17%
Childcare	39%	13%
Schools	35%	20%
Hospital	29%	29%
Social care	26%	26%

To what extent do you feel that you are able to influence the way you use each of the following services?	Able to influence	Not able to influence
Dentist	33%	33%
Childcare	33%	23%
GP	30%	35%

[5] Populus, on behalf of Which?, interviewed a random sample of 2,078 UK adults aged 18+ online between 15th and 17th March 2013.

University	30%	28%
Schools	27%	30%
Hospital	22%	45%
Social care	24%	36%

4.2 This demonstrates that public service providers need to have processes in place that allow users to understand the steps they have taken following a complaint, including how feedback is influencing providers' decisions and holding them to account. This requires clear mechanisms to be put in place that ensure that these actions are systematically fed back to their users, such as regularly publishing complaint handling reports.

5. How effectively do Government departments and public service providers use complaints to improve the service provided?

5.1 Our recent survey of GPs reveals a great variation in the use of feedback from consumers. Feedback is regularly reviewed by the management team at 53% of practices, 50% review national patient satisfaction survey results and only 38% compare them in relation to local practices. The lack of visibility of complaints procedures and action taken as a result of complaints and feedback helps to reinforce the impression that nothing will happen as a result of complaining.

5.2 A growing source of insight into complaints in some public services are online review websites. Websites such as NHS Choices and Patient Opinion, provide a useful channel for service users and can increase the transparency of the complaints process and outcomes. However, the increased use of these sites presents a risk that they will provide an increasingly disparate view of complaints and feedback, with feedback being left in a variety of different places and the complete picture never being captured. As a result, work should be undertaken to look at how this intelligence can be pooled for easy review by the public, as well as systematic review by commissioners and regulators. It is also important that these services are not viewed as a replacement for less public, offline channels for complaints.

5.3 The Parliamentary and Health Service Ombudsman (PHSO) has suggested that the current approach to NHS complaints does not provide a useful source of intelligence to commissioners and regulators to look at systemic issues of performance.[6] While NHS providers are required to report on their complaint handling performance, the PHSO has indicated that there is a lack of consistency in how this is done. The PHSO has pointed to

[6] 'Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England 2009-10'

the fact that there are no clear requirements about how summaries are reported and presented or to publish reports online. As a result, the PHSO stated that it is difficult for NHS managers to identify learning from across the NHS and for commissioners and regulators to compare the complaint handling performance of one NHS body with another.

5.4 Given the number of bodies responsible for monitoring quality in social care, similar concerns could be raised about whether information is being effectively shared. For example, if a user has a complaint about their care home or home care agency, there are currently up to five different bodies that they could be expected to report their complaint to - their provider, the local authority, the Local Government Ombudsman, the CQC or Local Healthwatch. Greater clarity is therefore needed about the appropriate route to complain. Without this consumers are unlikely to have confidence that their feedback will be passed on and registered at a regulatory level.

5.5 Lessons should be learnt from those industries where the sector regulator has assumed responsibility for monitoring the complaints systems of individual providers. In financial services, the Financial Conduct Authority (FCA) oversees a three stage process that sets out the way firms must handle complaints, including the time they must take to respond to various aspects, the role of the Financial Ombudsman Service (FOS) and what consumers can do if they are not satisfied with the decision of the FOS. The FCA requires financial services companies to record and publish complaints in a standardised way to enable comparisons across the industry. These figures have to be qualified, as those firms with a larger customer base will generally show a higher level of complaints but this is not necessarily reflective of the quality of their service. The same considerations should apply to public sector organisations, for example individual hospitals.

5.6 Lessons should also be learnt from recent developments in the private sector around greater consistency in the operation of Alternative Dispute Resolution (ADR) mechanisms across different sectors. The Department of Business, Innovation and Skills (BIS) has recently announced that they will establish a Competent Authority to fulfil this role as it implements the requirements of the European ADR Directive. This Directive also makes reference to the importance of standardised methods of recording complaints by different ADR bodies.[7] If complaints in the public sector are to allow meaningful comparisons in performance across providers or agencies, then greater consistency is needed in the way that complaints are recorded and the level of detail that they provide.

6. How aware are service users of the various ombudsmen (such as the Local Government Ombudsman, Financial Ombudsman and the Housing Ombudsman)?

[7] European Commission Recommendation, 12 May 2010, on the use of a harmonised methodology for classifying and reporting consumer complaints and enquiries.

6.1 Our research on complaints handling in the energy sector suggests that while awareness of the Energy Ombudsman (EO) is high (70%), a small number of people escalate their complaint to the Ombudsman (6%)[8]. It is possible that the high level of awareness for the EO is reflective of ombudsmen in general, rather than of the EO in particular.

6.2 Previous Which? research suggests that that the most commonly used ombudsmen were the Financial Services Ombudsman (3%), the Energy Ombudsman (1%) and the Local Government Ombudsman (1%). One fifth of consumers (21%) said they could not remember whether they had escalated a complaint to an Ombudsman[9]. Recent research in 2013, suggests that the majority of people do not escalate their complaints beyond the service provider. The top three reasons for this were not thinking it would do any good (47%), the complaint not being serious enough (28%) and not knowing who to take their complaint to (22%). This indicates that while lack of awareness of Ombudsmen is a barrier for some, it is not the overriding reason why people fail to take complaints further[10].

May 2013

[8] Which? survey, November 2011. Total sample of 8271, with 775 interviews with Which? Connect members.

[9] A representative sample of c.2,000 adults aged 16+ were interviewed in home in approximately 143 locations throughout the UK via the TNS Face-to-face Omnibus, September 2011.

[10] Populus, on behalf of Which?, interviewed a random sample of 2,101 UK adults aged 18+ online between 3rd and 6th May 2013

Written evidence submitted by Social Fund Commissioner (COM 13)

Introduction

I welcome this opportunity to submit evidence to the Select Committee. I reply in my capacity as Social Fund Commissioner, having been appointed as an independent statutory office holder by the Secretary of State for Work and Pensions to head the Independent Review Service (IRS)[1] which provides an external independent review of Jobcentre Plus' decisions across Great Britain on applications to the discretionary Social Fund. Payments from the Social Fund are targeted at some of the poorest and most vulnerable citizens in our society. Since the independent review process started in 1988, Social Fund Inspectors at the IRS have reviewed over half a million decisions and during the twelve months ending in March 2012 they reviewed over fifty two thousand decisions. Our decisions can only be challenged by judicial review and since 1988 we have been subject to twenty four judicial review challenges. The rulings in these cases have confirmed the robustness of our procedures and our independence. Changes stemming from the Welfare Reform Act 2012 have abolished certain elements of the discretionary Social Fund from March 31st 2013 thus bringing an end to my statutory office and the organisation which I head. My office will close at the end of July 2013.

Summary

- It is not my intention to comment at length on all aspects of the Inquiry. I will make some observations based on our experience about the manner in which learning points from complaints can be used, in a public service environment, to drive improvements in service.

- I believe that everyone involved in public service delivery has a responsibility to use complaint outcomes to influence improvements because they can be used in a positive way to refine the service which is provided. Pressure on public service budgets heightens the importance of resolving complaints quickly and effectively in order to prevent matters from escalating and avoid similar complaints arising in future.

[1] The Social Fund Commissioner's statutory duties and powers are set out in primary legislation at section 37 of the Social Security Act 1998 and include appointing Social Fund Inspectors and other staff as he thinks fit; arranging training as appropriate; monitoring the quality of Inspectors' decisions; providing advice and assistance as appropriate to improve standards; and reporting annually to the Secretary of State for Work and Pensions.

- To become an integral part of an organisation's culture, good complaint handling processes and effective use of associated learning points must be the responsibility of senior leadership. A clear focal point with responsibility provides an opportunity for consistency in complaint handling, combined with increased clarity for the public and staff.

- A standard definition of what constitutes a complaint, and a common approach towards recording complaints across public bodies, could result in complaints data that is more consistent and therefore allow comparisons between organisations that would be more informative.

- Whilst it is not realistic to set standard or specific timescales for complaints handling by public bodies, given variations in the complexity of their activities it should be possible to set out the broad standards which would underpin how complaint response timescales will be met.

1. My submission focuses on specific areas of the Inquiry that relate most closely to insights which are drawn from our case-based experience since 1988. The independent review which our Social Fund Inspectors deliver has a number of characteristics that distinguish it from conventional complaint-handling. The Inspector's review has a statutory basis and represents a unique procedure in administrative law in that it combines a review and appeal function in one process. Nonetheless, the independent review process and complaint-handling processes share common ground, in that both deal with expressions of dissatisfaction from citizens about their experience with public services.

2. In terms of any complaints about our work, I have appointed a specialist internal team within my organisation to investigate and resolve complaints about Inspectors' decisions or about our service delivery. This team's handling of complaints also undergoes scrutiny by an external panel which provides me with independent assurance about the quality and consistency of our complaint-handling. A brief overview of our complaints activity is that in the reporting year ended 31 March 2012, 5.5% of our total workload was the subject of a complaint either about the decision (2,792) or service (97). The total decision complaints upheld constituted 0.3 % of our workload for the year and the total service complaints upheld constituted 0.01% of our annual workload. Full details of our casework performance for the business year 2011/12 – including data about complaints - are set out in my last published Annual Report at:
   http://www.irs-review.org.uk/infocent/reports/ar1112/IRSAR2011_12.pdf

3. The Inquiry invites feedback on how effective Government departments and public service providers are at using complaints to improve service provision. I believe that everyone involved in public service delivery has a responsibility to use complaint outcomes to influence improvements and to refine the service provided. Some of the learning points we identify from complaints (and our other quality assurance processes) are internal to our organization whilst other learning points can sometimes have wider implications. Because the outcome of decisions on Social Fund applications can have significant implications for people's lives , especially those who are poor and vulnerable, it is important that learning points arising from complaints are captured and acted on. When learning points from our casework have significance for the original decision makers, who are located in Jobcentre Plus, we feed learning points back to them in order to improve standards. I describe below how we share learning points and best practice across our organisation.

4. Since 1997 our Customer Service Team has been the central point for dealing with complaints, both in relation to the service we provide or the outcome of the Inspector's review. Members of this specialist team will not have previously been involved with the decision making process or service delivery issues related to the case which has been subject of complaint. Prior to this, when various parts of the organisation dealt with complaints, it was less easy to create a complete and readily available pool of information from which it was possible to identify common trends and grievances. In our experience it is important to have defined staff taking ownership of dealing with a complaint. Establishing a central team to deal with complaints helps to achieve this, because a complainant is able to contact a named member of the Customer Service Team who will take responsibility for resolving matters. This avoids complaints being moved around different parts of the organization, ensures timeliness and a higher level of customer satisfaction with their complaints experience; even if the ultimate outcome may not be what they were seeking.

5. Our computerised records management system for complaints data is an effective resource that helps us to highlight emerging trends, service gaps, any other scope for improvement, or recurring themes with broader implications. This means that we can identify - easily and promptly - anything that is not working well, take action to put things right quickly and ensure that we learn from our mistakes.

6. Dealing with complaints has financial implications. Given the pressure on public service budgets this heightens the importance of resolving complaints quickly and effectively; preventing matters from escalating further and avoiding similar complaints arising in future. We identify and record complaints on the day of receipt as part of our commitment to resolving matters at the earliest opportunity and we deal with these grievances promptly. If the nature of a particular complaint means

that a swift response is not possible, we will keep the customer informed and provide a reliable indication of when our final response can be expected.

7. Systematic collection, collation and analysis of complaints data underpins our internal quality and improvement framework. Our evaluation of complaints data involves looking at the content of complaints and not just the statistics. I chair an internal Standards Conference which meets regularly and is a roundtable forum that includes senior managers and staff from other levels in our organisation whose work responsibilities involve them in either our internal process for monitoring quality or in front-line delivery of our review decisions.

8. The Standards Conference, which has usually met on alternate months, considers and evaluates findings from all parts of our quality assurance framework - including scrutiny of complaints data. In addition the Conference considers feedback from an external panel of independent people who assess the fairness, impartiality, openness, clarity and responsiveness of our complaints service. This panel met twice in the past twelve months in order to examine a random sample of forty anonymous complaints (with personal or other identifying details deleted) and to consider the manner in which we had handled them. I was pleased to note that the panel concluded that our complaint handling work is of a high standard.

9. The Standards Conference provides us with an opportunity to review and discuss areas for improvement. If we identify common trends in complaints we then look for any root cause in order to develop some specific solutions. Possible solutions might be to redesign a procedure or to provide tailored support in the form of training, guidelines, briefings or other types of development for our staff. I also chair our Quality Forum which is a roundtable staff meeting that formulates suitable solutions and arranges for them to be carried out. All of our staff receive feedback from these meetings in order to ensure that learning points arising from complaints, and other quality indicators, support the development of our staff, our policies and our procedures.

10. We also appreciate that some people do not want their name linked to a specific complaint, but may be dissatisfied with their experience of the service which we have provided. Our ongoing customer survey invites customers to provide anonymous insights about how we dealt with their case. Some customers who responded to our most recent annual survey have told us that although they did not get the decision outcome from us they actually wanted, they nevertheless appreciated a clear explanation of the reasons for the decision. Their responses also underline the value they place on prompt resolution of matters which affect their daily lives. Yet, they also want to feel that someone has taken the time to listen to their concerns and to understand their situation.

11. In order for it to become part of an organisation's culture, good complaint-handling and effective use of associated learning points must be led from the top. Both myself and our senior managers within the organisation demonstrate our commitment to learning from complaints by taking an active interest in the process and discussing these issues in the Standards Conference and Quality Forum. Quality assessment of the work of individual members of staff forms part of our performance appraisal process and takes account of complaints data.

12. Given that effective complaints handling requires commitment from senior leaders, there is an argument for appointing someone to provide a focus for leadership and governance of complaints systems across departments and their agencies. This should assist in providing clear and visible responsibility to achieve a consistent approach to complaint handling, increased clarity for the public and staff, a common working definition of what constitutes a complaint, transparency about how information from complaints has been used to improve matters for customers and publication of clear information by all public bodies about the process involved in making a complaint.

13. At present it is open to public bodies and departments to arrive at their own working definition of what constitutes a complaint. This definition may be a narrow one, or it may be wide enough to encompass any expression of dissatisfaction – made verbally or in writing – that requires a response. When departments and public bodies adopt diverse definitions of what represents a complaint, it can be difficult to draw meaningful conclusions about comparative complaint levels across these organisations. If a standard definition of a complaint and a common approach to recording complaints was adopted , the resulting complaints data would provide more meaningful comparisons between organisations. In addition, adopting a consistent, transparent working definition of what represents a complaint would provide clarity for the public and for staff alike.

14. A timely outcome is very important when responding to complaints, particularly where this relates to a payment or a service that is needed urgently. For this reason the timescales for responding to complaints should be as short as practicable to allow for suitable investigation of the case. Our casework experience demonstrates that individual cases can vary in complexity. However, we find that it is possible to respond to different levels of complexity by setting clearance targets that reflect that difference. It may not be feasible to set a standard, specific timescale for complaints handling by public bodies, given variations in the complexity of each organisation's work. However it should be possible to provide a lead to departments and public bodies by setting out the broad standards for complaint response timescales.

15. I note that the Parliamentary and Health Ombudsman published Principles of Good Complaint Handling. These principles provide public bodies with a broad framework to assist with consideration of complaints. We have actively considered our processes against the framework set out in the Principles and were pleased that we did not have to implement any changes. These Principles set out the types of behavior and standards expected from public bodies when dealing with complaints and it provides a valuable working guide for everyone involved in public service delivery. In my view it is important to have a set of guidelines, such as the Principles, that promote a consistent and effective approach to handling complaints and achieving improvements in service delivery.

16. I hope these observations are helpful to the Committee and its deliberations.

May 2013

Written evidence submitted by Trevor Buck, Richard Kirkham and Brian Thompson (COM 14)

Summary

- In administrative justice the complaints/appeal dichotomy should be bridged at all stages in the policy process: planning, implementation and oversight

- There is consensus on best practice in complaints-handling including user awareness, accessibility and support; appropriate redress and learning to make improvements but implementation of this guidance is deficient

- There is a need for collection and analysis of good data on complaints activity

- PASC should question the Cabinet Office and the MoJ on co-ordination and collaboration of administrative justice; and the DWP on how they implemented complaints reform, if they could provide a 'One Door' for complaints and appeals and how they are seeking to minimise disputes in universal credit and personal independence payments

Introduction

1. We are academic lawyers whose research specialisms include the administrative justice system. Administrative justice covers both resolving disputes about the delivery of public services and learning from those disputes to make service improvements. There are a range of techniques and institutions for resolving administrative disputes, but there is an important dichotomy in the design which separates complaints about service from appeals about legal entitlements and rights. This complaints/appeal distinction causes problems. It is not understood by the public who are confused about what they can do and who they may approach when they have a grievance. In terms of policy planning and operations, different government departments take the lead for complaints and appeals, and in turn those departments are subject to parliamentary oversight by different select committees. The position is complicated further by our asymmetric devolution settlement so that for some public services the territory covered can be the UK; GB; England and Wales; England; Scotland; Wales; and Northern Ireland.

2. The public need to be helped to navigate through this complex system and to be supported in their disputes about public services. This requires a more integrated, joined-up approach which has not been achieved. Indeed this aim may be said to have been adversely affected by the government's decision to abolish the advisory Administrative Justice and Tribunals Council which two House of Commons select committees thought had a valuable role to play and should be retained.

3. We welcome this inquiry by the Public Administration Select Committee (PASC) which has been prompted in part by the publication of the final *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, chaired by Robert Francis QC. The reaction to that report by the government has included the commissioning of a review of the NHS complaints procedure in England. PASC has rightly recognised

that its inquiry should range across the whole of government and public bodies' arrangements for complaints, as there are common issues and indeed failings.

4. We assume that PASC also wished to follow-up the report by its predecessor committee *When Citizens Complain*, in which it was suggested that there was evidence of a systemic problem with first-tier complaint-handling by government organisations and various proposals were made, including some which addressed accessibility to complaints procedures or were intended to emphasise the need to gain and act upon insights from complaints to improve service. All of these points were also identified by the Francis report as deficiencies in complaints handling at Mid-Staffs.

5. Those points about accessibility and learning are part of the burgeoning guidance on complaints handling. The Cabinet Office has under different governments produced guidance: *Putting It Right* (1995) came out of the Citizen's Charter and its Task-force on Complaints, and the successor initiative Service First which led to *How To Deal with Complaints* (1998). Guidance has also been produced for complaint handling for public bodies which sought accreditation under the Chartermark programme, and this was revised under the brand Customer Service Excellence (2007-8). In the same period the Parliamentary and Health Service Ombudsman (PHSO) produced three sets of guidance which were re-launched in a slightly revised version in 2009: *Principles of Good Administration; Principles of Good Complaint-Handling* and *Principles for Remedy*. The Local Government Ombudsman in England had first produced guidance on complaints handling in 1992 *Devising a Complaints System* and in 2002 this was revised and renamed *Running a Complaints System*.

6. In the NHS, the recently launched review of the complaints procedure is the fourth such exercise in England in 19 years. The process began in 1994 with a UK-wide report *Being Heard*. The new procedure was implemented in 1995 and its operation was then subjected to two UK-wide research projects in 1999 and 2001. As the NHS was a devolved competence, action following-up this research was a matter for the four Health Services. In England there was a revised scheme introduced in 2004 and then in 2007 a further review called 'Making Experiences Count' led to new arrangements across both NHS and social care complaints which began in 2009.

The Committee's Inquiry

7. In this section we address the data which will be useful to PASC in the conduct of this inquiry, answering those questions in the Issues and Questions paper on which we have information, but we also will identify sources and suggest issues which could be raised with some witnesses.

Aims & Objectives of Complaints Procedures

8. As we have shown above, there is a large body of guidance on complaint-handling and there is a broad consensus in this material that complaint procedures should provide appropriate and proportionate redress, as well as seek and acquire insight to improve service. As PASC's predecessor committee noted in its *When Citizens Complain* report, good complaint-handling requires a culture in public bodies which

invites and values complaints, so that complainants are taken seriously. As the Francis report on Mid-Staffs shows, serious repercussions can follow when this culture is lacking and complaints and complainants are not taken seriously. The degree and consequences of the absence of a proper public service culture in Mid-Staff is a tragedy and a scandal. The reports from the various Ombudsmen on their investigations, and in the annual surveys which the PHSO carries out in relation to the complaints it handles indicate that the implementation and achievement of the aims and objectives of complaints procedures is not as good as it should be. So we suggest that PASC questions witnesses about implementation in the next stage of the inquiry. Witnesses should be drawn from departments which have a leadership role in co-ordinating and collaborating over administrative justice, such as the Cabinet office and the Ministry of Justice (MoJ, and those departments (and their agencies) whose work attracts large numbers of complaints, such as the Department for Work and Pensions (DWP), HM Revenue and Customs and the Home Office.

Questions Seeking Empirical Data

9. We welcome the questions seeking empirical data on how Ministerial objectives for complaints procedure are realised; awareness, accessibility of complaints procedures as well as the time taken to resolve complaints, outcomes in terms of the redress provided and using complaints to make improvements in service. As we have said, there is a real issue with the scope and scale of implementation of best practice guidance. It is to be hoped that departments will provide written evidence supplying data on these issues.

10. A resource which PASC's predecessor committee had was the report published by the National Audit Office, *Citizen Redress: What citizens can do if things go wrong with public services* (2005). This report sought to map and quantify citizen redress in central government. It was not dealing with local government and several central government departments were unable to furnish the researchers with all of the data they sought. Despite this incomplete coverage, the report presented for the first time an indication of redress activity and its cost in central government.

11. It would be useful to have a more complete and up to date successor report. If representations to the NAO were successful so that they decided to commission a successor, its publication would be some time after PASC's inquiry was finished but it would provide data facilitating the continuing scrutiny of arrangements for redress. Since that report the NAO has published reports on learning from complaints about health and social care (2008); complaints handling by the DWP (2008), and the Independent Police Complaints Commission IPCC (2009). The IPCC was also the subject of an inquiry by the Home Affairs Select committee (2013).

Awareness & Accessibility

12. Amongst the topics covered in the NAO *Citizen Redress* report were the public's awareness of, and ease in accessing, redress. The verdict was that it was patchy. Various surveys, including those conducted for the Ombudsmen about their own services, indicate that the young, those in lower socio-economic groups and those in minority ethnic groups are much less aware of redress bodies and thus are under-

represented in their casework. Your predecessor committee recommended that there should be exploration of a common access point for non-emergency services, providing a single point of contact for impartial information on where to make a complaint or seek redress. The government response was not keen on a single portal preferring that there should be information to help the public complain to the appropriate body about their grievance. As the new GOV.UK website rolls out, it should be assessed on how well it enables the public to discover information about redress.

13. In her Shipman Inquiry report (2004), Dame Janet Smith noted in relation to NHS complaints that an online portal should not be solely a source of information but additionally have a helpline attached. Again in health, the Francis Report on Mid-Staffs considered the demarcation between those who receive a self-help pack and those regarded as vulnerable who would receive a fuller range of advocacy support from the Independent Complaints Advocacy Service. Francis recommended that greater support should be given to any complainant who requested it. This raises an important question as to the degree of information, advice and support which should be provided and it is a more difficult issue in a time of reductions in public expenditure. Even if it is accepted that some people should have less support than others, it is still imperative that information about redress is easy to find, and if intended for self-help, that it is fit for that purpose. It should be noted that the NHS procedure provides for independent advice and assistance. The lack of independence in the provision of information, advice and support is an issue for some complainants about all public services.

14. PASC may wish to speak to the Cabinet Office and the MoJ in order to check whether there is adequate information. Certainly in the field of appeals there is concern that legal aid reductions will lead to the diminished provision of information and advice which may mean that (a) those with well founded grievances do not receive information and thus do not pursue it, and (b) those with a misconceived grievance do not receive information and advice which would provide them with a better understanding of the situation and stop a misconceived challenge.

Learning from Complaints

15. It is a recurring theme in research about NHS complaints that there is a lack of resolve and capacity to grasp the learning opportunity provided by complaints. This is despite the fact that it is a key aspect of all complaints handling guidance, including the advice on the need for action taken at board level by both the Chief Executive and non-executive directors. The PHSO and the LGO will be able to offer a view on the situation with central and local government bodies. The AJTC has produced two relevant reports one *Putting It Right*: *A Strategic Approach to Resolving Administrative Disputes* (2012) which outlined a four stage cycle in disputes which identifies action to be at each stage:

    Preventing disputes by better legislative design, information and guidance

    Reducing dispute escalation through better communication for corrections & queries

    Resolving disputes using appropriate and proportionate methods; and

    Learning from disputes by seeking out insight and acting upon it.

16. In *Right First Time* (2011) some principles and practical steps were proposed to assist organisations design their procedures so to 'get it right first time'. Two case studies, highlighted what the UK Border Agency and the Criminal Injuries Compensation Authority had done to address criticism about the level and cost of appeals from their decisions.

17. As those examples show, some agencies do take action to learn from mistakes and criticism but it does depend upon whether agencies and departments are prepared to act and this may be influenced by whether there is some provision for oversight. Where complaints have been upheld by an Ombudsmen, there will be a check to confirm if the ombudsman's recommendations have been followed but this does not cover complaints which do not reach the ombudsman.

18. In the NHS there is provision for an annual return by trusts on complaints but this is statistical data and the Mid-Staffs case demonstrate problems with oversight provided by a process of reporting 'up the chain'. For it to work there must be someone who analyses it in an attempt to discern if appropriate action is being taken and in areas such as health and social care the regulator might be the appropriate body.

19. The proper situation should be that public bodies have internalised a public service culture and ethic which means that they do invite, value and act upon complaints. Where there is no regulator who could provide oversight, it might be possible to enhance transparency and accountability mechanisms. What might be done with central (and local) government bodies is to require that more information is published in their Annual Reports. Currently departments will refer to complaints about them which have been considered by the PHSO and present some statistics. This should be improved by including statistics and commentary on complaints which have been handled by their own procedures, including an analysis of trends and action taken to make improvements resulting from complaints. Where the department has an arms-length complaints handler as an intermediate stage between their own procedure and the PHSO, such as the Adjudicator for HMRC and the Independent Case Examiner for DWP, there should be data and commentary upon that stage including what action was taken in response to recommendations made by the intermediate complaints handler.

20. The requirement on public bodies to include robust statements of complaint activitiy in their annual reports ought to follow a standard methodology for the collection of such data, while allowing for relevant specialist information to be captured. We have in mind a system which could track and organise data collection into three areas:
    (i) 'core' data, for example, a standard identification of the number of customers' initial enquiries and the point at which they should be counted as substantive 'complaints', subject classification of complaints and the development of a formula to capture the cost of complaints ;
    (ii) 'sectoral' data, to capture relevant complaint activity in the main policy areas – for example, education, health, welfare, defence etc; and

(iii) ‘Departmental/Agency specific’ data, i.e. data where a case can be made for it being a significant subject-specific item of interest and learning within each individual department or agency.

Handling of complaints about complaints systems

21. We take the view that in a complaints process there has to be finality. In UK public services complaints procedures, complainants must first engage with the body which has caused the grievance as, in the majority of cases, this should enable it to be resolved quickly and affords a learning opportunity. There should be an independent complaints handler to whom a dissatisfied complainant can escalate their case. This should be the final stage. If a person is dissatisfied then there may be a review about the manner in which the complaint was considered rather than an appeal against the decision. This review may be carried out by a member of the ombudsman’s staff or, as we advocate, conducted by an external reviewer as is done at the Scottish Public Services Ombudsman and as was recommended for the LGO by a team of reviewers which included one of us.

22. We believe that, rather than the unhelpful, binary notion of ‘judicial’ v ‘non-judicial’ in the question paper, a more pertinent comparison can be made between ‘formal’ and ‘informal’ methods of complaint resolution; and this is also more comprehensible to users of complaint systems. It is equally important to know the *depth* of the investigative process used. First-instance level complaint systems have not been as hampered by the statutory remits of ombudsman offices, which in the past at least, have driven formality in the investigative process.

23. But complaint-handling systems do not always strike the right balance between the use of appropriate techniques to resolve grievances; see Baroness Fritchie’s review of the Health Service Ombudsman’s approach to complaints that NHS service failure led to avoidable death. That review was prompted by complainants whose cases had *not* been subject to formal investigation. In other circumstances an over-prescriptive formality will similarly be found to be inappropriate. There is little research in this area, and the balance to be struck between informal and formal resolution is specifically mentioned by the AJTC in their recent indication of where future research may need to be directed (2013).

Bridging the Complaints-Appeal Divide

24. We have mentioned this divide and it is important because failure to take account of it means that the position of those seeking redress is imperfectly understood. We urge that the MoJ and Cabinet Office are questioned about how they collaborate and co-ordinate. We suggest that PASC’s cross-cutting remit allows for consideration of the Tribunals and Administrative Justice Strategic Work Programme 2013-16, in which the MoJ outlines its plans to collaborate with other Whitehall departments and with the devolved institutions. PASC will be interested to know when the MoJ will respond to the Law Commission’s 2011 report *Public Services Ombudsmen*. There is a statutory target of 12 months for responding to a Law Commission report. The MoJ

reported in January 2012 that it hoped to respond by the summer of 2012 and then in its report of January 2013, it hoped to respond shortly.

25. We suggest that officials from the DWP should be called as witnesses because, following the critical reports on the complaint handling by the NAO and the Public Accounts Committee, the DWP set about reforming its procedures. They could be probed about how this is working and if improvements are being generated from analysis of complaints and of tribunal appeal decisions. The President of the Social Entitlement Chamber of the First-tier Tribunal has indicated how he sought to change feedback to the DWP. Feedback had been a review of their standards of decision-making as revealed in the appeals which the tribunal determined. They are now providing benchmark decisions in areas in which the tribunal offers guidance on difficult topics by indicating how they might be approached and the sort of evidence which would be relevant.

26. Another question for DWP is whether they might help the public bridge the gap between complaints and appeals by adopting a 'One Door' approach. This is a single access point for their customers' grievances in which a screening process could determine what was a complaint and what was an appeal and route it to the appropriate channel rather than expect the customer to make the identification and act accordingly. We suggest that the possibility of such a 'One Door' approach arises because section 102 of the Welfare Reform Act 2012 provides for a power to require consideration of revision of decision before it can be referred to the tribunal as an appeal.

27. The DWP and the MoJ collaborated in a pilot of a new approach to reconsidering decisions where an appeal had been lodged. This new approach seems to be in line with the AJTC's strategy for the second stage of reducing disputes. Under these proposals, there is an interactive process in which the official conducting a review or reconsideration instead of simply picking up the file and reading it also picks up the phone and talks to the customer which facilitates the discovery of new information which can lead to a revised decision. In the reports on 'Standards in Decision-Making' which the Tribunal President sent to the DWP, the most common reason why an appeal was successful was that new information was uncovered in the tribunal hearing.

28. The opportunity might also be taken with DWP witnesses to explore the extent to which the DWP has sought to engage in the first stage in the AJTC approach, to seek to prevent disputes arising in the new benefits, Universal Credit and Personal Independence Payments. The AJTC's advice identifies simplifying complex legislation, providing clear guidance and information, and additional independent advice, the development of a right first time culture and making strategic interventions. In relation to this last point the AJTC noted that in their joint initiative on fraud and error, the Cabinet Office, DWP and HMRC whilst acknowledging the extent of error, devoted more of their attention to fraud and debt than to ensuring that they 'pay the correct amount to the correct claimant every time'.

May 2013

Written evidence submitted by the Centre for Public Scrutiny (COM 15)

This response draws on our thinking about transparent, inclusive and accountable public services; our experience of developing policy and supporting successful practical programmes; and our work to help implement public service reform locally.

Key messages

- Better services are likely from commissioners and providers who are transparent, inclusive and accountable but those who are unapproachable or unclear about outcomes risk losing touch with people who use services – handling complaints in ways that focus on learning and improvement (not just meeting process targets) can help build trust.

- The approach to leadership and governance adopted by individuals and organisations is important – there is an important difference between strategic direction and operational performance and commissioners and providers should refresh their culture and values to reflect quality and safety alongside value (both financial and social) – complaints are an important way to gather insight about credibility.

- Council scrutiny is a key mechanism for providing local assurance about the quality, safety and value of services – government, commissioners and providers should invest in the development of council scrutiny alongside other mechanisms of insight (for example local Healthwatch and social housing tenant panels).

- Respecting the privacy of individuals and groups is important but commissioners and providers should take opportunities to demonstrate how they have used complaints as insight to make improvements not just in relevant services but across organisations as a whole.

About CfPS

CfPS (an independent charity) is the leading national organisation for ideas, thinking and the development and application of policy and practice to promote transparent, inclusive and accountable public services. We support individuals, organisations and communities to put our principles into practice in the design, delivery and monitoring of public services in ways that build knowledge, skills and trust so that effective solutions are identified together by decision-makers, practitioners and people who use services.

We work across government (for example with the Department of Health, Department of Communities and Local Government, Home Office, Department of Work and Pensions), with the Local Government Association and with stakeholders across primary and acute care (for example with the NHS Confederation, NHS Alliance, Foundation Trust Network, Care Quality Commission, Independent Reconfiguration Panel). We support individuals, organisations and communities through published guidance, events and a network of expert advisers.

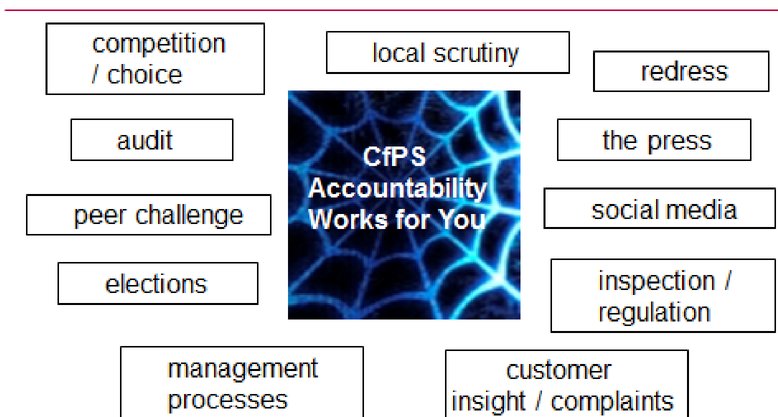
CfPS believes public services should be transparent, inclusive and accountable. In the context of complaints about public services these principles should be applied to ensure that commissioners and providers understand and respond to the experiences of people who use services.

Why transparency, involvement and accountability are important

Leaders and organisations building a culture based on these principles are more likely to demonstrate themselves as credible to people who use services and communities. The Centre's 'Accountability Works for You' framework can help leaders and organisations to better reflect our thinking about good governance. Acting in transparent, inclusive and accountable ways means working with different people in different ways – for example citizens, people who use services and elected representatives. Our four mutually reinforcing principles of good scrutiny can be adapted to support accountability in public service reform:

- Responding to constructive 'critical friend' challenge.
- Understanding the voices and concerns of the public.
- Supporting independent people to take responsibility for their role.
- Driving improvements in services.

CfPS has identified that accountability is experienced in many ways as illustrated in our 'web of accountability'. Customer insight, complaints and redress are important parts of the accountability framework for public services:



Focus on learning and improvement

CfPS notes that the Committee is initially focusing on the NHS but is seeking evidence of general principles that can apply across government. Although commissioners and providers have discretion to act locally, this is often in the context of national policy frameworks set in Whitehall or practice guidance issued by professional bodies. The distinction between 'central and local' is not always clear to people who use services and this risks adding complexity and delay to complaints processes. CfPS believes that experience of local delivery should inform national policy and practice – the national Ombudsmen and sector regulation schemes are important sources of evidence about how outcomes from policies are being experienced locally.

The Francis report describes what happens when an unapproachable organisation is unclear about the outcomes it is achieving - it loses touch with people who use services and their families. This is a risk all commissioners and providers of public services should learn from and work hard to overcome. Complaints and redress are an important way for national and local commissioners and providers to build trust by demonstrating understanding about how individual citizens experience services and decisions so that improvements are made to the ways services are planned and delivered. This can help the proper analysis and management of information about complaints and customer insight to feed in to business planning, commissioning and scrutiny arrangements.

Jointly with the Local Government Ombudsman[1], CfPS has identified some common enablers and barriers to using insight from complaints effectively:

Enablers

[1] 'Aiming for the Best' http://cfps.org.uk.surface3.vm.bytemark.co.uk/publications?item=129&offset=0

• creating a culture of learning and improvement
• providing people with lots of ways to give feedback
• leadership in sharing lessons across the organisation
• a co-ordinated resource that maximises the impact of learning

Barriers
• treating complaints as an opportunity to defend practice
• poor communication with citizens and complainants
• silo approach to complaints, no sharing of lessons across the organisation
• little connection between feedback, insight and strategic planning

Learning from complaints provides opportunities for services to be shaped by people's experiences. These can often be people who are traditionally considered 'hard to reach' and who may be less successful at navigating complex public services or complex complaints processes. For example in the NHS the distinction between Patient Advice and Liaison Services; local Healthwatch; opportunities for feedback via social media; and formal complaints processes risk complexity and confusion. Added to this is a risk of lack of clarity around the distinct responsibilities of providers and commissioners. Where complaints involve the interaction between several services (for example health, education and social care) the risk of complexity and delay becomes greater.

When developing a policy or service model, it is almost impossible to anticipate all potential variables of implementation and impact. This is why complaints should be viewed as a strategic resource providing rich and diverse perspectives. They can illustrate how well goals and standards are being achieved from the point of view of the needs and aspirations of citizens and on any unintended consequences of the way policies are implemented or decisions are made. In healthcare, there should be an explicit link between the rights and pledges set out in the NHS Constitution; the NHS Mandate; the NHS Outcomes Framework; and peoples experiences of services. The framework established for accountability in health and social care is comprehensive – this is not necessarily reflected across other public services. Even with a comprehensive framework in health and social care the evidence of 'responsiveness' is patchy.

When service provision depends upon individual assessment and allocation of scarce resources, such as special educational needs or community care services, it may be difficult to collect volume data. Different approaches and techniques will be needed to learn from complaints related to this type of personalised service – for example, valuable insight can come through listening to people's stories to learn from their experience and balance quantitative and qualitative information. This may require sensitivity, respecting the privacy and confidentiality of the citizens involved.

Leadership and governance

The approach to leadership and governance adopted by individuals and organisations is important. In healthcare, NHS England should be clear about how learning from complaints will inform its commissioning of primary care and specialised services and about the ambition underpinning guidance it publishes for Clinical Commissioning Groups that are at the heart of the reforms and are fundamental to the success of the vision for improved healthcare and health improvement. In healthcare and social care, the distinction between management and clinical practice and the distinction between organisations and professional bodies adds complexity to complaints processes that is not always easily navigated by people who use services.

We think the Francis Inquiry is a 'wake-up call' to refresh culture and values to improve patient care and we have urged all NHS bodies to pledge to refresh their culture and values in light of the Francis Report. We think better services are likely from commissioners and providers who are transparent, inclusive and accountable but those who are unapproachable or unclear about outcomes risk losing touch with people who use services and families – which happened at Stafford Hospital with catastrophic results.

It took too long for people's concerns about services at Stafford Hospital to be taken seriously and the Francis Report is another reminder about what can go wrong when people who use services struggle to get their voices heard. The scale of failure at Stafford Hospital was shocking but the underlying issues are not unique – the Kennedy Report put a spotlight on patient involvement over 10 years ago and there have been reports about unacceptable healthcare and social care since.

Poor clinical and management practices contributed to what happened – patients received poor care on the wards and the Board were not checking what was happening. Performance management systems designed to check up on poor practice showed on many levels that Mid-Staffordshire was a successful Trust – whilst in reality it was failing patients. Variations in performance were recorded and explained in ways that made it difficult to be clear what was happening to patients – and concerns about operational performance were overshadowed by apparent strategic successes. We think that accountability is not just about publishing data – this is important but should be linked to mechanisms that bring a reality check to make sure that patients experiences are properly reflected.

Responding to complaints is a key ingredient of responsive services. Effective complaint handling goes further than having proper procedures – it also means promoting an organisational culture that is open to challenge, makes the most of opportunities to learn and is willing to change.

A proactive approach to complaints can also help identify underlying issues, for example relating to vulnerability or safeguarding. Complaints can be a rich source of citizen insight. Complaints are unsolicited and should be valued as illustrating what a 'customer journey' may be like for the citizen in practice. Complaints can help identify

risks and weaknesses across services that should inform future planning and commissioning decisions.

We think that there are opportunities for better investment in building relationships and joint working between people with a non-executive role (in health, for example lay people on CCG Boards, local Healthwatch, non-executives and public governors of Foundation Trusts, council scrutiny and regulators). Investing in independent support for better scrutiny and accountability and building on work undertaken in the past would reflect our view that public scrutiny and accountability are:

- about openness and credibility not 'red tape' - they are vital to ensure fairness, probity and safety.
- important checks and balances that add value to our democracy – there are lessons from the past about what can go wrong when they do not have respect or investment.
- a bridge between powerful people and the public to build knowledge, skills and trust – this is vital to solve the challenges we face.

Council scrutiny

Robert Francis identified that it was difficult for anyone 'on the outside' to check what was happening inside Stafford hospital. This is also a risk across other aspects of public service, especially as arrangements for delivery become more diverse and possibly less transparent under commercial contract arrangements. Scrutiny by local councillors is an important part of the framework of local accountability and we have urged councils, the NHS and other agencies to embrace the value we know scrutiny can provide and support and resource council scrutiny well.

In a changing political and financial environment, there is a vital role for non-executive councillors to influence decisions about planning and delivering services through councils' overview and scrutiny function. Council scrutiny can be a powerful force for improvement and innovation at a local level. They can help organisations to strengthen democracy for the future by involving citizens and service users in scrutiny as a mechanism for strengthening accountability. Scrutiny provides a chance to take an overview of complaints handling, to assess corporate culture towards complaints and assess the extent to which complaints currently provide learning across whole organisations which drive improvement. In carrying out this role, scrutiny can draw lessons from individual complaints, either for individual services or for organisations as a whole.

By hearing from people directly affected by policies and services, scrutiny can get an understanding about the services people and communities value. Outcomes from this kind of work could add value to decision-making processes by introducing considerations of 'value', not just 'cost'. By hearing from service users about what they value in their community and about their aspirations for service delivery, scrutiny can

strengthen the evidence-base about what matters to communities, helping those who plan and deliver public services to make judgements about the best ways to achieve short term savings and longer term improvements.

Through their overview and scrutiny function, councils can use a range of creative and innovative ways to gather an evidence-base about what matters to service users and how they would like to see future services planned and delivered around their needs and aspirations. Scrutiny is a process that allows people to 'tell their stories', helping to bring a reality check to data about performance and complaints. This can be powerful, but needs careful planning and facilitation.

Overview and scrutiny committees have a track record of involving service users in scrutiny reviews. However, tackling the challenges ahead will require them to go beyond traditional approaches and engage service users about a much broader range of issues, building 'citizen insight' into the heart of service improvement. At a time when difficult decisions need to be made about future funding for public services and when public involvement is low, learning from service users through scrutiny can strengthen public trust.

Together with the Local Government Ombudsman, CfPS has identified questions designed to provide a 'reality check' to the use of complaints by public services:

Cultural factors:

Establishing a transparent, inclusive and accountable culture:

- is there a commitment to transparency, inclusiveness and accountability in respect of policies and services?
- are there examples of policies and services changing as a result?
- if not, how can the principles best be introduced?

Promoting a positive culture about the value of complaints:

- is the complaints policy about a bureaucratic process or is it focused on learning and improvement?
- are issues arising from complaints discussed by appropriate politicians and/or senior leaders?
- how is learning from complaints spread across the organisation?

Operational factors:

Understanding how feedback is gathered:

- how can people provide feedback about their experience?
- do people know they can provide feedback?
- what are the most and least popular methods that people use to give feedback?

Identifying best practice in handling insight through complaints:

- does the approach to complaints mirror best practice?
- are there any lessons to be learnt from customer relationship management in other sectors?
- how do we compare with similar areas?

Exploring the information held about complaints and how it is used:

- who has responsibility to handle complaints?
- are there arrangements to review levels of complaints and outcomes from them?
- how is learning from complaints built in to future decision-making?

Exploring the information provided by Ombudsmen:

- have Ombudsmen investigated any decisions or services?
- are there any trends in complaints received identified in Ombudsmen Annual Reviews?
- have Ombudsmen made any specific comments about the way the organisation handles and learns from complaints in its individual investigations or summarised in Annual Reviews?
- does wider information about Ombudsmen cases provide useful information about how services can be improved and risk managed? Do Ombudsmen reports about other areas prompt the question 'could it happen here?'
- how do politicians and senior leaders assess risks and assure themselves that services are performing well and that people are treated fairly with respect and dignity?

Strategic factors:

Making use of the business planning or commissioning cycle:

- how does insight from complaints influence strategic planning?
- is learning from complaints a feature of contracts with providers?
- how is citizen feedback routinely captured?

Conclusion

In light of recent issues across public services and public institutions we think that local mechanisms for public voice (for example local healthwatch and social housing tenant panels); council scrutiny; regulators and Ombudsmen; professional bodies; and Parliamentary Select Committees should be clear about how they can best work together to provide assurance about quality, safety and value.

We have tried to make a positive response to the Committee's call for evidence about complaints in public services, using the Committee's initial focus on the NHS as a starting point but drawing out common principles that can be applied nationally and locally. We have set out in this submission some of the fundamental principles that we believe should be built in to arrangements for complaints handling so that learning from complaints helps plan and deliver better services.

May 2013

Written evidence submitted by Parliamentary and Health Service Ombudsman (COM 16)

1. An effective complaints system is a core part of a well-designed and managed public service. When handled well, complaints make a difference. A good response to a complaint can ensure justice for the individual. Importantly, it can also ensure that learning takes place so that mistakes are not repeated and the quality of service improves for all. However, the reality is that too often complaints do not make the difference that they should.

2. Most members of the public who bring their complaint to us tell us that they are looking for three simple things: an explanation of what went wrong, an apology and an adequate remedy, and action to be taken so that other people do not have to experience the same poor service. But sadly, the public perception of complaining is so poor that research we commissioned in 2012 showed:

    - the overwhelming majority (64%) of people who complain do not believe that their complaint will lead to any change; and

    - 39% of those who want to complain about a public service do not make a complaint. Almost 60% of this group told us that their reason for not complaining was that they believed the complaints process would be complex, involve them having to chase a response and that they feared nothing would change as a result of their complaint.

    As a member of the public said to us, the complaints system '*has not been designed with the public in mind*'. That is a damning indictment of much of today's public service complaint handling. We owe it to those who have a complaint to change this and to ensure that their complaints make a difference in the future.

3. As a result, the Parliamentary and Health Service Ombudsman very much welcomes the opportunity to give evidence to the Public Administration Select Committee for the inquiry *Complaints: Do they make a difference?*

    Our simple answer to your question is 'they can and they should'.

4. Often public services:
    - have complaints systems that are difficult for the public to find and navigate;

- are slow to respond to complaints, deal with them defensively, and use confusing and bureaucratic language in their responses;

- inadequately equip their staff in terms of knowledge, training and skills to deal with complaints and do not empower staff with the authority to swiftly fix problems that are highlighted by complaints;

- fail to track, monitor and measure complaints; and

- neglect to ensure that responsibility for complaints, and learning from complaints, is held at the very top of the organisation.

5. Our experience and research tells us that for this situation to be turned around public services need to change the way in which they operate in five key areas. We have created a mnemonic, GRASP, which helps to give these ways of working an easy to understand structure:

   Governance: Complaints are taken seriously at the very top of an organisation, inform leadership decision making and contribute to how the leadership is held to account.

   Records: Complaints are treated as critical management information and intelligence about what is happening.

   Accountability: Accountability for complaints runs from staff on the frontline to board level. There is clarity around who is responsible for listening and putting things right. Complaint handling is an integral part of how services are judged by those charged with scrutinising the service, including Parliament.

   Standards: It is made clear to customers where and how to complain, and they are made to feel that complaints will be welcomed and acted on quickly. Customers are dealt with as individuals – helpfully, promptly and sensitively. The standards adopted by public services reflect the *Ombudsman's Principles of Good Complaint Handling*.

   Practice: All staff have the knowledge, skills and training to deal with complaints at the earliest point possible. They also have the necessary authority or access to people who can get things done and support them in getting a problem sorted. Staff are supported in developing the confidence and humility to say sorry in a meaningful way, to take action to fix problems flagged by complaints, and a culture of openness is nurtured at all levels.

6. In this submission, we explain the application of these points in more detail; and we set out a number of specific recommendations that we hope the Committee will include in its report.

GOVERNANCE: THE IMPORTANCE OF LEADERSHIP

7. Good complaint handling requires strong and effective leadership. Those at the top of a public service should take the lead in ensuring good complaint handling, with regard to both practice and culture. And those who scrutinise the leaders should ensure that delivery on complaint handling is a core part of their scrutiny and certainly not just a tick-box exercise.

8. Nowhere is this evidenced more strongly than in the *Francis Report* on the inquiry into the failings in Mid Staffordshire hospitals. The Report highlighted serious failures with the complaints process and the performance of the Trust Board. It said the Board '*did not listen sufficiently to its patients or its staff or ensure the correction of deficiencies brought to the Trust's attention…*'.

9. However, when it comes to dealing with dissatisfaction and complaints, Mid Staffordshire is not an isolated example. We know from our own investigations that many others are failing to respond well. For this to be fixed there needs to be a transformation in governance. There are three we believe it is useful for boards to focus on:

- *Number of complaints*:
    - Are there any trends in the number of complaints?
    - What do we think the reasons are for these trends and what action do we need to take?
- *Learning from complaints*:
    - Are there any trends in the subjects of complaints?
    - What do we think are the reasons for these trends? What have we learned from complaints, customer feedback, staff feedback and feedback from the Ombudsman?
    - What has been improved about our services and administration as a result?
    - What further action do we need to take to address any outstanding issues identified?
- *Experience of complaining*:

- What are our service standards for complaint handling? What is our performance against those standards?
- What are our customers and the Ombudsman telling us about the public's experiences of making a complaint? When did we last audit our complaint handling, and what were the findings and recommendations?
- What action has been taken or needs to be taken as a result?

RECORDS - THE POWER OF INFORMATION

10. Insight from complaints plays a critical role in indicating early symptoms of a problem with a public service. The ability of public services to identify patterns, trends and themes promptly is central to making change happen quickly, and they should be embracing the opportunities provided by the growth and evolution of new technology to achieve this.

11. On its own though, the collection and collation of complaints data is not enough to lead and drive improvement. Just because there is lots of information does not mean we know a lot. Data needs context to turn it into knowledge and that context is only provided through true engagement with the complaint and the complainant.

12. Dealing with complaints effectively will save money and an important area for further research is to cost the extent of such savings and how the learning from complaints to make systemic improvements in services can drive even greater savings.

ACCOUNTABILITY:

13. Accountability for complaints does not stop at the leadership of a public service organisation. Ministers and senior civil servants have to be called to account by Parliament on their complaints record. We believe that performance on complaints should be given greater emphasis as part of the 'administration' requirement that government departments and agencies are required to meet in their reporting to select committees (see select committee terms of reference to examine 'expenditure, administration and policy' in departments and agencies under their jurisdiction). We also think that PASC's ongoing role scrutinising performance on complaints across government departments and agencies will be key in highlighting the importance of this issue.

14. The landscape of providers of public services has become significantly more complex in the years since the Committee last examined the issue of complaints. More public services are being provided by private or third sector organisations, potentially causing confusion for the public as to who is accountable for dealing with a complaint.

15. The complainant should not have to research the detail of which exact body is providing the different elements of the public service that they are using. It is arguably even more important in cases where there are a multitude of bodies involved in the provision of a service that there is clear accountability and a clear single route for complaints.
16. Private sector providers and those from the third sector need to ensure that they are meeting the standards expected of public services, including the adoption of the *Ombudsman's Principles*. Moreover, commissioners should include the quality of complaint handling as a criterion in awarding contracts and ensuring that providers have systems to embed the learning from complaints.

STANDARDS – ACCESS, PROCESS AND SUPPORT FOR COMPLAINING

17. NHS and central government services do a great job for most people most of the time. But sometimes things go wrong. Our research into what the public wanted from a complaints system revealed strong evidence of a need that is not being met, some of which was set out in paragraph 2 of this submission.

18. Our research also told us that young people, people with learning disabilities and BME groups, in particular find it hard to complain.

19. Even when people had complained, they spoke of the obstacles they encountered: of not being listened to, not being kept up to date, and feeling that they were not being taken seriously. Complaining about public services takes confidence, persistence and, sometimes, sheer luck. For too many people, the process is dispiriting and the outcome seems hollow.

Access

20. It is the duty of a public service provider to ensure that anyone who wishes to complain can do so. All public service providers should have systems for complaint handling which are clearly signposted. In practice, though, we sometimes find that staff do not know about the complaints procedures, or if they do, fail to follow them. In one of our health cases a complainant was even told '*there is no complaints department*'.

21. There should be clearer, more consistent and more widely recognised branding for the complaints systems in public services. A live debate within public services is the possibility of greater co-ordination of portals for complaints; for example through the creation of a 'Complaints Hub' which would be recognised and easily accessed by any patient with a complaint about their experience in the NHS in England. We are enthusiastically participating in discussions on this with the NHS, the Department of Health and health regulators, and also believe that it could provide a model of value in other areas of public service.

22. Often, people who need to make a complaint may be vulnerable or for some other reason need greater explanation and support in communicating. It is not enough to hope that they will get this support from family or friends. There should be well-resourced advocacy support in complaints systems, and further consideration given to whether funding for advocacy support should be ring-fenced. Advocacy support should also be clearly branded and recognisable. Consideration should be given to locally commissioned advocacy services operating under a brand that exists and is recognised nationally, such as in the Health Service, *Healthwatch England*.

23. Another source of confusion and a potential obstacle to complaining is the difference between a complaint, a dispute, and an appeal. Not only is this little understood by the public but sometimes by those delivering the service and complaint handlers.

24. As the Committee has previously stated, there is a real distinction between complaints and appeals – the former concerns processes and handling, the latter concerns accuracy or correctness of decisions. However, both are about taking another look and there are interesting questions to address about if, when and how the handling of the two should come together.

25. There should be research on the level of confusion amongst the public on the different roles of tribunals and ombudsmen, as well as exploration of how those roles could be clarified and made to make more sense to the public, better support public service in learning from complaints and deliver better value for money.

Process

26. In our reports and other publications, we tell stories of individuals who, when things went wrong, struggled to get themselves heard. Many of the complaints we see are about small, seemingly insignificant mistakes; administrative errors of letters

unanswered; or documents unread. These issues should not need to come to us. They only do so because of the inability or refusal of public services to put matters right when they had an early opportunity to do so. The fact that they reach us at all is due, in no short measure, to the tenacity of those making the complaints.

27. For an individual member of the public who wants to complain about the service they have received from one, or more, public bodies, such a multitude of different systems adds to confusion or frustration. This confusion and frustration is also demonstrated by the fact that nearly three quarters of people who complain to the Ombudsman do so too soon, before they have completed a public body's own complaints procedure. The reasons people most commonly give for bringing their complaint to us early include 'going straight to the top', 'wanting a quick result' and 'a loss of confidence' in the public body.
28. If you compile a picture of the different ways government departments and public bodies handle complaints, as we did in our report *Responsive and Accountable? 2010-11*, you will find that the public is faced with a plethora of complaints systems, mainly developed by the individual departments and bodies to suit their needs, not the individual's. We are not advocating a 'one-size-fits-all' approach. Such an approach would preclude flexible processes, designed to be relevant and accessible to the needs of different customers. However, there should be greater commonality and more use of simple, familiar and easy to understand processes.

PRACTICE

29. Good complaint handling does happen. One of the conclusions reached by the Committee in its report *When Citizens Complain* was: '*There is clearly a need for a centrally co-ordinated official effort to champion good practice in complaints handling across government and the public services*'.

30. Since then we've been working alongside the Cross-Government Complaint Forum. Led by the Department for Work and Pensions, this Forum is addressing the issues we raised in our report, *Responsive and Accountable? 2010-11*, about the often haphazard nature of government complaint handling. The Forum has generated new high level standards and a complaint resolution framework that will increase transparency, accountability and consistency in complaint handling. The implementation and application of such standards will help drive up quality and also improve the customer experience.

31. We believe that this could be taken further by the professionalisation of complaints handling in public services. We believe that an accreditation methodology should be developed for complaints handlers, and that all staff delivering public services should have elements of skills training in complaint handling as a compulsory part of their professional development.
32. Specifically, in the health service in England, we believe that accreditation in dealing with complaints should be included in the training and development programmes being delivered by Health Education England.

SUMMARY OF RECOMMENDATIONS

33. In too many cases the present complaints system is not delivering justice for the public or value for money for taxpayers. Our experience tells us that the key to unlocking this situation is robust leadership.

34. To that end, we hope that the Committee's report will include the following specific recommendations for leaders in public services and Parliament to implement:

    - **Parliament** should demand that performance on complaints is made an explicit part of the 'administration' requirement that government departments and agencies are required to meet in their reporting to select committees (paragraph 13);

    - **boards** should be asking specific questions about the number of complaints, learning from complaints, and the experience of complaining (paragraph 9);

    - **commissioners** should include the quality of complaint handling as a criterion in awarding contracts and ensuring that providers have systems to embed the learning from complaints (paragraph 16);

    - **senior leaders across government** should develop clearer, more consistent and more widely recognised branding for complaints systems in public services (paragraph 21);

    - **senior leaders across government**, in particular those in the Department on Health, must ensure that there is well-resourced advocacy support, which again is clearly branded and recognised, and give consideration to whether funding for advocacy support should be ring-fenced (paragraph 22);

- **senior leaders across government and the NHS in England** should develop an accreditation methodology for complaint handlers, and ensure that all staff delivering public services have elements of skills training in complaint handling as a compulsory part of their professional development (paragraphs 31 and 32);

- **the Cabinet Office** should commission research to cost the savings which can be made from dealing with complaints effectively , and to demonstrate how learning from complaints to make systemic improvements in services can drive even greater savings (paragraph 12); and

- **the Ministry of Justice** should commission research to establish the level of confusion amongst the public on the different roles of tribunals and ombudsmen, as well as to explore how those roles could be clarified and made to make more sense to the public, better support public service in learning from complaints and deliver better value for money (paragraph 25).

May 2013

Written evidence submitted by NHS Confederation (COM 17)

Executive Summary

- The NHS cannot afford to be complacent about complaints. Following the publication of the final report of the Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust (the 'Francis Report') there is both an obligation and an opportunity to make the NHS safer, more compassionate and fully accountable to the people it serves. Only by being fully transparent can organisations learn how to improve when things go wrong. The NHS needs to listen to patients and act on their genuine concerns; the failure to do this at Mid Staffordshire resulted in tragic consequences - we cannot let that happen again. Throughout our response we highlight Francis' recommendations and the lessons for complaints handling in the NHS from the Francis Report. We also provide examples of the work going on in NHS organisations to use complaints to drive up quality.

- Effective feedback and complaints systems are an integral part of an open and transparent culture in the NHS. Complaints should be seen as part of a continuum that is central to an organisation's wider focus on the quality of care and services it provides. It is crucial that organisations encourage patients, their families and carers to share their comments and criticisms, and for NHS bodies to act on feedback before concerns escalate into complaints.

- The increase in the number of commissioning bodies in the NHS has led to changes in advice and complaints services. We have serious concerns that following the NHS reforms the complaints system has become more difficult to navigate and risks leaving patients confused about who to complain to.

- Every healthcare provider should report the number and type of complaints made, and how they are acted upon, in their Quality Account, which is published annually. This would provide a vehicle for standardisation in data reporting and allow for some comparison between organisations.

- However, it is important to emphasise that the volume of complaints received by an organisation is not necessarily an indicator of that organisation's quality. While a high number of complaints might never be considered a good thing, it can be a reflection of an accessible complaints system or an open culture in an organisation. An overly simplistic focus on the number of written complaints should not be allowed to undermine the innovation and good work being carried out to improve the NHS' approach to complaints handling.

- It is also important to bear in mind that complaints cannot be compared like for like across providers, given their different sizes, populations, services and complaints processes, and should certainly not be seen as the only or main source of information about service quality. Sharing 'soft' intelligence between commissioners, local Healthwatch and regulators is also a critical part of monitoring quality; concerns about quality may in some cases be anecdotal and not reflected in hard data. Quality Surveillance Groups (QSQs), which bring together organisations and their respective information and intelligence gathered through performance monitoring, commissioning and regulatory activities, offer an opportunity for this.

- QSGs have the potential to provide local oversight of complaints, and take responsibility for gathering, joining up and sharing intelligence. The complexity in the new commissioning system and the diverse range of providers in the health sector means there is a risk that information could be duplicated or patterns in the data missed. This risk must be mitigated if the NHS is to learn the lessons from Mid Staffordshire; sharing local and regional intelligence through QSGs can support this.

- While the litigation process is an important source of redress, there is strong evidence that if something goes wrong with their care or treatment, most people want an apology, an explanation of what went wrong, and an assurance that the problem will not recur. Avoiding litigation can reduce both the stress involved for complainants and the cost for the NHS. The health service needs to try different approaches and should encourage greater use of mediation as part of this. The NHS Confederation is supporting the scoping of a pilot restorative redress scheme, which aims to provide a way of restoring the relationship between complainants and those who have cared for them via non-legal procedures that promote mutual understanding and transparency.

1. Complaints as part of a wider quality focus

1.1 The NHS cannot afford to be complacent about complaints. In light of the recent report into failings at Mid Staffordshire NHS Foundation Trust, every part of the NHS is committed to driving up quality and patient experience; effective complaints handling can play a key role in achieving this. Changing the culture and attitudes so that feedback is valued is fundamental to improving services and patients' experiences of care. Many patients don't wish to make a complaint but simply to raise a concern and see action taken. Local systems need to facilitate this.

1.2 Complaints are an important source of feedback, which can and should be used positively and constructively to improve services. But formal written complaints are just the

tip of the iceberg. Robert Francis concluded that the current system focuses too much on complaints and not enough on opportunities to make comments and suggestions in neutral settings. NHS organisations should also be considering issues raised with their Patient Advice and Liaison Service (PALS) as well as gathering feedback more widely and proactively, in order to understand the common experiences of their patients, the majority of whom we know are unlikely to complain even if they are dissatisfied with the service they receive.

1.3 Similarly, recognition of the importance of getting initial complaint handling right is essential. There is strong evidence that if something goes wrong with their care or treatment, most people want an apology, an explanation of what went wrong, and an assurance that the problem will not recur. Getting these things right makes it less likely that the complainant will seek further, formal redress.

1.4 Healthcare organisations with high reporting of patient safety incidents and 'near misses' tend to be higher quality organisations, with an open culture and focus on learning from adverse events to improve services. This is an important lesson the NHS has learnt from the aviation industry where there are high levels of incident reporting. A high number of complaints or PALS inquiries can result from the accessibility of complaints procedures and an organisation's willingness to encourage feedback in order to improve services.

1.5 Therefore an overly mechanistic focus on the number of written complaints, year on year, particularly at a national level, could undermine much of the good work to change the approach of NHS organisations to complaint handling.

1.6 The Francis Report identified that the feedback, learning and warning signals available from complaints had not been given a high enough priority at Mid Staffordshire. This was demonstrated through inadequate staffing levels in the PALS office and a lack of interest in complaints at board level, insufficient support for complainants and poor information sharing between the trust, commissioners and the regulator. Every member of staff in the NHS needs to recognise the value of patient feedback and complaints, from ward to board level, and there are good examples in the NHS of organisations embracing whole organisation approaches to patient experience.

1.7 NHS leaders must demonstrate to their organisations their dedication for caring for the populations they serve, which means listening to what they have to say. Nottinghamshire Healthcare NHS Trust pioneered a joined up and creative approach to engaging all parts of the organisation in listening and responding to patients' experiences. Each directorate now has an action plan that identifies the key issues people have raised and what is being done to

tackle them. The trust collates an annual involvement report showcasing the changes made, highlighting individual stories and actions taken across the trust.

2. How easy is it to complain?

2.1 The NHS Constitution outlines patients' rights to have any complaints they make about NHS services acknowledged within three working days and to have it properly investigated. We believe that the Constitution sets out in clear terms patients' rights when making a complaint and the NHS' responsibilities in handling complaints. Ensuring that patients, their families and staff are aware of their rights and responsibilities as set out in the Constitution will play an important role in making sure that the principles it advocates are played out in practice. We believe that the revised Constitution needs to be accompanied by a large-scale and ongoing publicity campaign to make sure that everyone receiving and delivering care knows what their rights are and how to exercise them.

2.2 When an individual has a concern or complaint about a service provider and wishes to address this directly to that organisation, we believe the process for doing so is relatively straightforward. The NHS Choices website sets out advice for patients on the NHS complaints process[1], and identifies that the first step will normally be to raise the matter (in writing or orally) with the practitioner concerned, or with their organisation. The legislation covering NHS complaints procedure[2] sets out the obligations on NHS bodies, GPs and other primary care providers, and independent providers of NHS care to make arrangements for dealing with complaints. This includes a duty on all NHS organisations to make information about their arrangements for dealing with complaints available to the public. It is current NHS best practice to acknowledge complaints as soon as they are received and set out a timescale by which the complainant will receive a fuller response.

2.3 Every NHS trust in England also has a PALS (Patient Advice and Liaison Service) and PALS officers, whose role is to advise, support and listen to patients, their families and carers. PALS officers are available in all hospitals, where they are well-placed to flag up areas where services can be improved and often work to achieve quick resolution of problems without having to resort to the formal complaints processes. To fulfil their role effectively, PALS officers need to be properly trained and their offices must be visible, well-publicised within a trust and open at convenient times. PALS also provide an early warning system for NHS trusts and monitoring bodies by identifying problems or gaps in services and reporting them.

[1] http://www.nhs.uk/choiceintheNHS/Rightsandpledges/complaints/Pages/NHScomplaints.aspx
[2] http://www.legislation.gov.uk/uksi/2009/309/regulation/4/made

2.4 While physical visibility and easy accessibility of PALS is essential, it also needs to be joined up with an organisation's complaints service. At Cambridge University Hospitals NHS Foundation Trust the integration of PALS and complaints service was part of a strong organisational focus on delivering high quality care and creating a culture of openness.

2.5 While complaints procedures and PALS remain largely unchanged within NHS provider organisations, we are concerned that the complexity of the new commissioning arrangements introduced by the Health and Social Care Act has the potential to leave patients confused about where to complain if they do not wish to do so directly to their provider, or if their complaint involves more than one organisation.

2.6 Prior to April 2013, all Primary Care Trusts (PCTs) also provided a PALS service, and patients were able to complain to the PCT as their service commissioner (and as such their representative and advocate) as well as or instead of complaining directly to any provider of their care.

2.7 In the new system, there is no longer a single local commissioner with comprehensive responsibility for the full range of services that an individual patient might receive. Instead, Clinical Commissioning Groups (CCGs) are now responsible for commissioning the majority of secondary care, community services and mental health services in their local area, while NHS England, through its Local Areas Teams (LATs), commissions primary and specialised services, such as neurological and secure mental health services and local authorities are responsible for commissioning public health interventions, such as sexual health and tobacco cessation services.

2.8 Responsibility for primary care complaints management therefore transferred from PCTs to NHS England on 1 April 2013. Patients who have a comment or complaint about a GP, dentist, pharmacy or optician, which cannot be resolved locally with the practice manager, now need to contact NHS England if they wish to take it further.

2.9 However, we believe the process for raising such concerns is currently unclear and poorly signposted. Ensuring that this process is transparent is particularly important given NHS England's responsibility for holding contracts for GP services and the recognised reluctance of patients to complain directly to their GP. NHS England must provide clear information to patients and the public about its complaints process.

2.10 Patients are also entitled to raise concerns and complaints with NHS England about other services directly commissioned by it area team (including specialised services), but

patients who have a comment or complaint about a local hospital, mental health or community trust however, would need to contact their CCG.

2.11We were concerned that NHS England's 'Lessons learned from wave one of CCG authorisation'[3] highlighted that for many CCGs, "insufficient information was contained in the constitution regarding the systems in place to deal with patient complaints and how the complaints would be handled and actioned". While CCGs will have addressed such gaps in their policies and procedures in order to be authorised, we remain concerned that their capacity to monitor the quality of services and use intelligence about complaints to inform their commissioning decisions is significantly reduced. It is important to recognise that CCGs are relatively new bodies dealing with a number of competing priorities, and have much smaller management teams than PCTs.

2.12 While some CCGs, such as North East Lincolnshire, have retained the PALS arrangements that were in place in the PCT, others have adopted new approaches. For example, Wandsworth CCG has replaced the PALS with a 'Customer Care' department.

2.13 The NHS Confederation supports the autonomy of CCGs, who should be able to decide on the services they provide, including their advice and complaints services, based on what is locally appropriate. Nonetheless, it is essential that changes in advice and complaints services are clearly communicated to patients and the public, and, wherever possible, patients and the public are involved in decisions about service changes.

2.14 Complaints received by CCGs may also be delegated by CCGs to a Commissioning Support Unit (CSU) to investigate. NHS England advises[4] that this raises a number of information governance considerations. CSUs are not legal entities in their own right; they are hosted by NHS England with staff employed by the Business Services Authority and as such they cannot therefore be Data Controllers as defined by the Data Protection Act. Consequently, in order to comply with fair processing requirements, CCGs must ensure patients are aware that their complaint and records will be passed on to the CSU and who to contact should they have any concerns about how their information is to be sed.

2.15 Overall, we are concerned there is a significant risk that the dispersed responsibilities for service commissioning, and therefore complaints handling, will make it more confusing and difficult for patients to complain to their commissioners about services they have received, and that their reduced management capacity will make it more difficult for commissioners to

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[3] http://www.england.nhs.uk/wp-content/uploads/2012/09/wave-1-lessons-learnt.pdf
[4] http://www.england.nhs.uk/2013/04/12/ccg-bulletin-issue-32/#complaints

respond effectively. In this context, we are particularly concerned that in terminating the nationally held Independent Complaints Advocacy Service (ICAS) contracts, there has been a loss of specialist advocacy services. Specialist independent advocacy services to help complainants raise their concerns can be beneficial to both the patients and the organisation providing care, particularly in helping to clarify the concerns and expectations about what should happen and when. While we welcome the government's recognition that local authorities should decide who they commission local NHS advocacy services from, we are concerned that the funding allocated to local authorities for these purposes is not ring-fenced, which could lead to variation in the quality of services across the country. Advocacy services should be a priority and information about services must be accessible and easy to understand.

3. Learning from complaints

3.1 Effective complaints systems are an essential part of an open and transparent culture in the NHS. Complaints should be seen as part of a continuum that is integral to an organisation's wider focus on the quality of care and services it provides and organisations should act upon feedback to improve the quality of services they commission or provide.

3.2 Acting upon complaints requires effective complaints systems, monitoring arrangements and joined-up data sharing arrangements to be in place across the system. Information about complaints should be shared across providers, commissioners, regulators and Healthwatch organisations. Central to the failures in care at Mid Staffordshire, was fragmentation in gathering and sharing information. Although a range of people, including patients, GPs and local MPs had identified problems at the trust, no one had overall responsibility for taking an overarching view of concerns and joining up information to identify patterns in poor care. Similar failures led to the appalling abuse of patients at Winterbourne View. We are also concerned that the loss of a central collection point for complaints and the complexity in the new system following the implementation of the Health and Social Care Act (as described above) risks the NHS not learning the lessons from Mid Staffordshire.

3.3 Robert Francis recommended that commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. For commissioners, using complaints data and feedback is an essential part of the commissioning process and intelligence from complaints can be used to drive up quality. Commissioners must have access to up to date data about providers but how this works in practice needs to be locally agreed.

3.4 The NHS Confederation believes all providers of NHS care should be open and transparent about the complaints they receive and how they have responded to them. One way this could be achieved is through the inclusion of a key indicator for complaints as part patient experience measures in the Quality Accounts published annually by each healthcare provider, including independent sector organisations. This would act as a vehicle for standardisation in data reporting across all providers and allow for some comparison, with the caveat that trusts cannot be compared like for like as they will range in size, services provided and in their complaints handling processes.

3.5 In addition, while the greater diversity of NHS providers is to be welcomed, it is important to ensure there is someway of joining up complaints data to gain an overarching perspective. Patients are rightly entitled to complain about the health care they receive to either the provider or commissioner of that service. As one provider may have multiple commissioners, there is the potential for complaints about the same provider to go to a number of different commissioning organisations. It is essential therefore that commissioners share information with each other about complaints made about services, and that providers share information about the complaints they receive with all of their commissioners. This will reduce the risk of information being duplicated or lost in the system.

3.6 The NHS Confederation believes Quality Surveillance Groups (QSGs) could play an important role in sharing intelligence and identifying patterns in complaints data. A network of QSGs is being established across the country, with QSGs acting as a virtual team across a health economy, bringing together organisations and their respective information and intelligence gathered through performance monitoring, commissioning and regulatory activities. By collectively considering information and intelligence, QSGs will work to safeguard the quality of care that people receive. Local QSGs will be made up of representatives from NHS England, CCGs, Healthwatch, the regulators, NHS Trust Development Authority, Public Health England and the Local Education and Training Board.

3.7 These Groups will meet to consider all providers delivering care in the region, examining hard data and sharing soft intelligence regarding any concerns about the quality of services being provided to the local population. Given the difficulties in comparing complaints data like for like, this opportunity to share soft, anecdotal intelligence about providers is especially important. The meetings also offer an opportunity to look collectively at the data which may assist in identifying patterns in complaints that may otherwise have been dealt with in isolation.

3.8 It is also essential that CSUs who deal with complaints on behalf of CCGs feed information back to CCGs about the process and outcome of complaints. It is the

commissioners who are able to take action if they have concerns about the quality of care provided by a service for which they hold the contract, and considering this information is an important part of the decision making process.

3.9 Newly established local Healthwatch organisations are also expected to have an important role in relation to monitoring complaints. However, although the increase in patient choice and a greater diversity of NHS providers is to be welcomed, this will make it difficult for Healthwatch to gather comprehensive information on complaints about the services that local residents use. Without such information, local Healthwatch is unlikely to be able to exercise effective scrutiny of complaints. Healthwatch is an important part of the system, and local Healthwatch bodies must be sufficiently resourced to deliver what they are being asked to do.

3.10 An effective complaints system requires a whole system approach to openness and transparency in the NHS. We welcome the Care Quality Commission's strategy to make clearer its role in complaints handling and to work with the Department of Health to explore how to resolve the wider confusion about the overall system of managing complaints. The NHS Confederation is also supporting the review of the NHS complaints system currently being led by Ann Clwyd MP and Professor Tricia Hart.

Cambridge University Hospitals NHS Foundation Trust has adopted an integrated approach to its PALS and complaints service, with the PALS office open outside office hours and on weekends. This is part of a strong organisational focus on delivering high quality care and creating a culture of openness with its staff, patients and the public.

The trusts' elected governors, including patients, run a number of different work streams (including one on quality and public engagement). It runs in-house quarterly patient surveys and runs monthly focus groups to gather feedback from patients about how the trust could have improved their experience.

A Patient Experience Committee, which includes patients, reviews all complaints and feedback. If necessary, a ward may be referred to their Patient Experience Support Team to help identify any challenges and what needs to change. All areas that have worked with the team have demonstrated a significant reduction in complaints and an improvement in patient experience survey results.

Nottinghamshire Healthcare NHS Trust has used a variety of methods to capture and report on patients' experiences to drive action across teams.

Methods included:

- a simple, eye-catching survey
- an innovative strategy for managing online feedback via Patient Opinion
- a patient experience impact opinion workshop for 80 staff, to encourage support for the project
- collating all survey feedback, Patient Opinion feedback, complaints, forums and meetings
- creating partnerships between service users/volunteers to support teams across the trust to be beacons of good practice for all aspects of patient feedback and to spread this to other teams
- developing an accessible patient experience area on their website so that the range of feedback they collect is online, rapidly visible and easily usable by staff and the public and so improves accountability and drives change.

Each directorate now has an action plan that identifies the key issues people have raised and what is being done to tackle them. The trust now collates an annual involvement report, which accompanies the annual report, showcasing changes made, highlighting individual stories and the actions taken across the trust in response to the feedback received.

Actions include:

- the Releasing Time to Care Project, which enables staff to spend more time with service users by improving efficiency. This has led to 14 per cent more direct care time with service users
- the eating disorder service has employed a dietician for three days a week
in forensic services all patients at Wathwood hospital are now offered 25 hours a week of meaningful activity, such as sports, horticulture and therapy sessions
- patients painting pictures for the walls in the learning disability assessment and treatment unit to improve the environment
- a series of 'ask about…' cards, to improve communication and involvement around medication, physical health and care planning.

4. Achieving a balance between non-judicial and judicial investigations and remedies

4.1The NHS Litigation Authority annual accounts showed that the NHS paid out £1.2bn in litigation costs in 2011-12. While the litigation process is an important source of redress, in light of the financial challenge facing the NHS this is a significant cost. The litigation process can also be slow and in some cases yield perverse results.

4.2 The health service needs to try different approaches and should encourage greater use of mediation as part of this. The NHS Confederation is supporting the development of a pilot project to explore the potential for a restorative redress scheme, which aims to provide a way of restoring the relationship between complainants and those who have cared for them via non-legal procedures that promote mutual understanding and transparency.

4.3 Recognition of the importance of getting initial complaint handling right is essential. There is strong evidence that if something goes wrong with their care or treatment, most people want an apology, an explanation of what went wrong, and an assurance that the problem will not recur. Getting these things right makes it less likely that the complainant will seek further, formal redress.

About the NHS Confederation

The NHS Confederation represents all types of organisations that commission and provide NHS services. It is the only membership body to bring together and speak on behalf of the whole of the NHS. Our members include acute trusts, clinical commissioning groups, community health service providers, foundation trusts, mental health providers and a growing number of independent and voluntary sector healthcare organisations.

May 2013

Written evidence submitted by By Elizabeth Derrington (Independent Complaints Reviewer for Land Registry and Partner with the Independent Complaint Resolution Service (ICRS)), Jodi Berg (Independent Complaints Reviewer for the National Archives, The Children's Commissioner for Wales and partner with ICRS) and Ros Gardner (partner with ICRS)

We are specialists in the field of complaint handling and dispute resolution in the public sector, currently providing external complaint review services for Land Registry and the Solicitors Regulation Authority. We are active members of the Ombudsman Association (OA), and Elizabeth Derrington is a current member of the OA's Executive Committee. We believe that we can shed light on a number of the questions the Committee is looking into.

Summary

We address questions 1-6 only as these are the areas in which we have most direct experience. Our main points are as follows:

1. **Objectives and design of complaints systems** Complaints systems should be accessible, accountable and consistent in approach, but flexible enough to meet different needs. They should also provide value for money and contribute to service improvements. They should include provision for external review.

2. **Using complaints to improve service** Land Registry has a well-established system for ensuring that complaints are used to improve service to customers. It is a model that could be useful elsewhere.

3. **How quickly do complaints systems deal with legitimate grievances and provide redress?** It is best for complaints to be resolved quickly and simply as close as possible to the source of the problem. If this is not possible there should be a clear escalation process. It is essential to maintain throughout a sense of momentum towards resolution.

4. **How easy is it to complain?** Government departments should take responsibility for recognising dissatisfaction and implementing the relevant complaints process. Swift complaint recognition and a clear complaint pathway maximise the chances of resolving the complaint, and keep costs to a minimum.

5. **Non-judicial and judicial investigations and remedies** There is potential to reduce costs and improve outcomes by being clearer about the relationship between judicial and non-judicial investigations.

6. **Public awareness** Public bodies and companies in the private sector should take responsibility for making service users/customers aware of their complaints policies and procedures, including the option of independent review.

1. What objectives should Ministers adopt when considering how complaints about Government and about public services provided by Government are handled?

All those using public services should have a clear route for raising concerns and complaints.

For the benefit of service users, and to ensure public credibility, complaints systems should be:

- Easy to access and use - information about the system should be readily available to all service users; there should be a clear pathway through the system, with information at each stage about next steps.
- Accountable – there should be clear standards and targets, and published reports on performance.
- Consistent in approach – systems should be based on consistent principles (the Parliamentary and Health Service Ombudsman *Principles of good complaint handling* are generally accepted within the complaint handling community), and follow recognisably similar procedures.
- Flexible and responsive to the needs of different users including those who are vulnerable, disengaged, or excluded.
- Able to deliver timely and appropriate corrective action and/or redress.
- Include arrangements for independent review.

For the benefit of service providers and the public in general complaints systems should be:

- Designed to contribute to improvements in service delivery and reduce complaints.
- Able to reflect the specific needs and characteristics of different organisations.
- Designed and implemented so as to provide value for money – by ensuring that complaints are handled proportionately and efficiently and that the lessons of complaints feed-back directly into better service delivery.

The criteria we have proposed draw on recent research by Varda Bondy and Andrew Le Sueur for the Public Law Project (*Designing redress: a study about grievances against public*

bodies published August 2012 www.publiclawproject.org.uk). The research report compares different complains systems and aims to identify the principles that make for effectiveness.

2. How effectively do Government departments and public service providers use

complaints to improve the service provided?

In our experience service providers do not, in general, have effective mechanisms for ensuring that the lessons of complaints feed back directly into better service delivery. A striking exception is Land Registry, which has a well established and effective system using complaints to drive customer service improvements. A team of staff from a range of disciplines meets regularly to address recommendations the ICR has made in reports on complaints. The role of the team includes deciding what action to take, and planning and monitoring implementation of change. The team has been responsible for overseeing close to 100 different changes in practice and procedure. The attached article (*Learning from complaints: completing the virtuous circle* published in the Ombudsman Association Newsletter April 2012) describes Land Registry's system in more detail.

3. How quickly do complaints systems deal with legitimate grievances and

provide redress?

Often not quickly enough. It is fairly obvious that the sooner a grievance is resolved the better. For this to happen the first requirement is that the customer's dissatisfaction should be recognised promptly. Staff need to be clear about what constitutes a complaint, to know that recording a complaint will be seen as a positive action, and to have authority to provide immediate redress. In our experience, failure to recognise complaints when they are raised is a significant delaying factor. For complaints that are not resolved immediately there should be a clear escalation process with set timescales at each stage. It is fair to say that customers, especially where the issues are complex, may not be concerned so much about the absolute speed of response as to know that the problem is being looked into and when they can expect to receive a response. Nonetheless it is important that timeliness is monitored and that causes of delay are eliminated.

4. How easy is it to make a complaint about a Government department or agency,

and how could this be improved?

In our experience this varies. The essential first step is that users should be directed to information about the relevant complaints procedure. Depending on the nature of the relationship between the department/agency and its service users, this may be most appropriately provided in the letter giving notification of a decision or in response to an

expression of dissatisfaction. It is also essential that it should be easy to find information about how to complain on the department/agency's website.

The idea of a single point of contact is mentioned at question 9. In principle we are supportive of the idea. It is important, however, that potential complainants should be aware of it, and should not add to cost for service providers. It is also essential that the information provided should be accurate and up to date. We suggest that it would be worth exploring the possibility of this service being provided by the Ombudsman Association (whose website already includes a section to help members of the public find the right ombudsman for their complaints).

As already mentioned it is important that complaints procedures should be accessible to vulnerable, disengaged, or excluded groups, and simple to follow. Departments/agencies and their staff also require ongoing support and encouragement to see complaints in a positive light, as a tool for improvement, rather than as evidence of failure.

5. Do complaints-handling systems achieve the right balance between non judicial

and judicial investigations and remedies?

Complaints handling systems focus on administrative/service issues while judicial investigations look at decisions and decision-making. In our experience, however, grievances raised by service users often relate both to administrative/service issues and also to decisions. It is confusing for the service users to be told that there are quite separate procedures for addressing the different strands of their complaints.

It is difficult to see a way of removing this confusion entirely without major restructuring of the whole of administrative justice. We believe, however, that it would be worth exploring the benefits of more interaction between courts/tribunals and complaint handlers. Often complaint investigations are suspended to wait for the outcome of judicial proceedings (though the court tribunal may well not be aware of the existence of the complaint). This delays resolution of the complaint, sometimes for many months. In fact, however, the issues addressed by the court/tribunal and the complaint handler are quite discrete. Liaison between complaint-handlers and courts/tribunals could identify cases where resolution of administrative/service issues would simplify the judicial decision and vice versa. In addition service users would experience a much more '*joined-up*' approach to their problems.

6. How aware are service users of the various ombudsmen (such as the Local

Government Ombudsman, Financial Ombudsman and the Housing

Ombudsman)?

The internet has made it much easier for service users to research options for pursuing complaints. The determined complainant has little difficulty in obtaining information about available ombudsmen and external complaint reviewers. But this does not take into account the perspective of vulnerable, disengaged and excluded groups. It is essential, therefore, that departments/agencies/organisations, when giving final responses to complaints, should clearly signpost the option of requesting an independent review by an ombudsman or external complaint reviewer.

May 2013

Written evidence submitted by Office for Legal Complaints (COM 19)

1. The role the Office for Legal Complaints (OLC) is to be responsible for ensuring that there is an independent Ombudsman service – the Legal Ombudsman - to consider complaints about legal services provided in England and Wales. The purpose of the Ombudsman is to provide a single gateway for consumers of legal services to channel their complaints while at the same time driving systemic improvement by feeding back to the profession information and methods to improve, in accordance with the regulatory objectives of the Legal Services Act 2007.

2. This paper seeks to provide information and analysis drawn from Legal Ombudsman (LeO) experience to assist the Committee consider the objectives for this enquiry, namely, do complaints make a difference?

Introduction

3. The current complaints system spans public and private sectors; the interface and distinctions between those two areas are increasingly blurring, as recent developments in providing access to redress for social care, housing advice and bailiffs indicate. We seek to share some background about the Legal Ombudsman and its learning in this area. Our strategic position is in line with that stated within the Ombudsman Association annual report - that we are here to serve the public interest, to help underpin public confidence in the bodies and businesses that we cover and provide insight from our experience about the importance of complaints in delivering fairness, redress, and access to justice. We are also here to emphasise the importance of systematic learning and feedback from complaints to improve standards across sectors.

4. We have read your issues and questions paper regarding complaints handling focusing particularly on the sections focused on complaints about Government departments and their agencies. Our response focuses on issues that link to Legal Ombudsman experience.

5. This paper will cover:

- gaps within the complaint system and the current gaps and inconsistencies in redress available to consumers;
- the issues faced by consumers when wanting to make a complaint, including navigating their way around the system and access to redress; awareness of the Ombudsman role; entry points for complaints and powers of redress; and
- opportunities for implementing a more strategic approach given developments such as the EU Directive regarding alternative dispute resolution.

Gaps and inconsistencies in redress

6. Ombudsmen may have existed for over 200 years in continental Europe but are a relatively new innovation in the UK – the first, the Parliamentary Ombudsman, was introduced in 1967. Until recently Ombudsmen have remained a reasonably minor part of the redress landscape.

7. However, there has been a significant expansion in the number of Ombudsman schemes in the UK. The Parliamentary Ombudsman (which has subsequently inherited the role of overseeing complaints about the Health Service) was joined in 1973 by the Local Government Ombudsman, Insurance (1981), Banking (1986), Pensions (1991), Prisons (1994), Financial Services, consolidating eight existing schemes (2001), and the Ombudsman Services Ltd in 2002 (covering telecoms, energy, some surveyors and estate agents). But those are just the main schemes; the membership of the Ombudsman Association now numbers over 70, covering most arms of the state and private industries as diverse as furniture, removals, glaziers and waterways.

8. The legislation which set up the Legal Ombudsman was passed in 2007 and it went live in late 2010. Its powers have been increased to cover prospective clients alongside those who have received a service and its maximum redress limit extended to £50,000, high but still far short of the recent increase of the Financial Ombudsman to £150,000.

9. Between them, Ombudsmen cover many, if not most, service transactions people participate in during our daily lives. And Ombudsmen do not just resolve individual complaints but are playing an increasingly strategic role in seeking to influence the behaviour of those sectors that they shadow. In the case of the Legal Ombudsman, many of the cases investigated since it began have raised serious questions about the consumer-friendliness of the traditional lawyers' hourly charging model, for example, and we are been seen by some as part of the pressure encouraging moves by legal providers towards fixed or at least predictable pricing. Also, FOS decisions played a significant part in the identification of the PPI misspelling scandal and the decision of the banks to set aside some £13 billion to pay the resultant compensation bill.

10. Ombudsman schemes deliver clear benefits. Ombudsmen provide speedy, free and accessible justice to many people who would never get access to the courts. The breadth of the remit of Ombudsmen (for all that it carries risk of arbitrariness and inconsistency) allows them to pursue ideals of justice and fairness rather than merely seek to attribute blame. Ombudsmen first aim is to resolve disputes between provider and consumer by mediation and negotiation. And by taking the lessons back to consumer and provider alike, they reduce the likelihood of future consumers having the same experience.

11. But the expansion of number of Ombudsman schemes has largely taken place without addressing the question how new schemes fit with others or with the formal legal structures to which they were designed to be an alternative. The individual schemes do not add up to a coherent Ombudsman system from a consumer or sectoral perspective: schemes vary markedly in their

formal status and philosophy. Some are embodied in statute and bound by rules; others created to meet a statutory set of requirements and a small number are entirely private and voluntary.

12. The historic abundance of Ombudsman means that there gaps and inconsistencies in terms of access to redress. There are overlaps across schemes; in the legal world for instance, consumers seeking to complain about legal expenses insurance might either need the assistance of the Financial or the Legal Ombudsman depending on whether the complaint was about the sale of the insurance or the legal advice gained after the insurance had been activated to inform a claim. We have protocols in place to signpost people between the organisations; it remains challenging even for informed consumers to be able to effectively navigate the system without considerable investment of time and effort. Alongside this, the increasing blending of private and public sectors also adds to the confusion around where jurisdictional boundaries lie. For instance, with the applications of the Institute of Charted Accountants in England and Wales (ICAEW), Institute of Chartered Accountants of Scotland (ICAS) and the Association of Chartered Certified Accountants (ACCA) to become approved regulators in regards to probate, the professional boundaries between accountants and lawyers are the next to become increasingly blurred. This will add to the matrix in an already complicated landscape.

13. Another challenge is with the relationship of the Ombudsman model to the formal structures of law and justice. Successive Governments have pushed conciliation and mediation as a faster, effective and economical alternative to formal legal structures, for instance in cases of family breakdown. The Ombudsman model is one which offers an informal, quicker – and cheaper – alternative to the courts. Ombudsmen themselves are continually moving to more streamlined and front-loaded models that seek to encourage early intervention and, ultimately prevention. The development of online consumer behaviours will ensure we continue to be challenged to innovate to remain informal, quick and relevant to consumers. Looked at from this perspective, Ombudsman schemes become less of a informal deviation from the accepted legal norm of the courts and tribunals system and more a possible harbinger of an alternative, fragmented, "privatised", method of delivering justice. Recent commentary[1] about the increasing importance of redress in light of the Jackson reforms gives some flavour of this; with the Ombudsman, rather than the courts, becoming the single point of contact for consumers seeking justice.

Consumer detriment, business burden and regulatory simplification

14. The experience of the Legal Ombudsman is that complaints are a key way for consumers to express dissatisfaction and seek recompense and censure for a provider. Aside from simply shopping with their feet, pursuing a complaint can achieve longer lasting impact on service provision in future across a sector rather than simply with a single provider. Redress mechanisms have a key role to play in empowering the consumer and ensuring confidence in service

[1] See for instance www.legalfutures.co.uk

provision. The Legal Services Consumer Panel Chair noted in the context of the NHS[2] that In launching a review to ensure that the NHS listened to, and acted upon, patient concerns, that the Health Secretary had stated:

"complaints can be the earliest symptom of a problem in an organisation, and the NHS should use them to learn from and improve their service"

15. There is a well-documented business case for offering redress in areas where there is an asymmetry of information between a provider and a consumer. In these cases access to redress ensures consumer detriment is put right and also increases consumer confidence in a sector.[3]

16. Ombudsmen also impose burdens on industry – the Legal Ombudsman is funded by the legal profession rather than taxpayers. The cultural benefits of having robust access to redress for legal services consumers arguably outweigh this burden. However the nature of any redress scheme is that it remains linked to the overall debate about regulatory simplification and the importance of proportionate mechanics to support and promote a sector. The legal services market itself; diverse and fragmented, split between unregulated and regulated communities means a significant access issue for consumers, particularly with an increasing online offer of DIY legal services. Navigating which are regulated – and therefore have redress attached to them – and which are not is complicated even for regulators and the Ombudsman, let alone individual consumers. Because of this, the redress available across "legal services" is also disparate and fragmented. In order to make redress in such a market effective, the options are either to simplify the regulation of the market itself or simplify the redress mechanism available.

17. The complexity does not end with a simple dichotomy of regulated and unregulated entities. There are new entrants to the market - super practices with commoditised online legal services, offshore global firms and alternative business structures (ABS) - whose existence demonstrate that the distinctions between what is a legal and non legal service are eroding quickly. Some of these businesses are subject to multiple regulatory and redress costs and demands. While the regulatory landscape may remain confusing for some time, it is difficult to understand why redress could not be simplified.

18. Industry has the time and incentive to understand the regulatory and redress complexities. Consumers rarely do. We have significant concerns about the impact that these innovations are having on consumers with regards to their rights to access redress. Consumers require clarity about when and why they are able to access redress – they have this for some of these business models and service providers but not for others. The complexity of services and barriers to entry for the consumer leaves lessons learned skewed – Ombudsman can feedback easily on those cases

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[2] Blog 21March 2013

[3] Mapping Potential consumer confusion in a changing legal market, University of Leicester (Legal Ombudsman), October 2011; Economic research into regulatory restrictions in the legal profession, European Economic (Office of Fair Trading), November 2012

within their jurisdiction. Where there is no access to redress, some few complex cases where the Ombudsman must grapple with jurisdiction provide glimpses of a deeper problem; however there is no systematic insight available in these areas despite indicators of consumer detriment. For those that come to the Ombudsman prematurely or are signposted to be told that we cannot assist because it is out of our jurisdiction many prefer "not to bother" to pursue their original complaint. In 2012 -13, the Legal Ombudsman received around 800 complaints that, after more detailed exploration, were concluded to be not within its jurisdiction. If is therefore not surprising that some consumers of legal services are also confused at the complexity of accessing redress.

19. In those cases where redress is available, depending on which Ombudsman scheme may have locus, consumers are then faced with ADR schemes having significantly different powers, meaning available remedies can vary markedly. For the Legal Ombudsman, even as a comparatively new scheme, there are questions over whether our governance and jurisdiction would have been designed in the same way had these innovations been better understood when the Act was being drafted. One of the principles the Legal Services Act 2007 emphasised is choice: ensuring the consumer is able to make informed choices, based on quality. It has been noted[4] that in the context of legal services, it is difficult for consumers to judge the quality of service delivered. If the consumer finds it hard to judge quality and make effective choices on that basis, this is compounded by confusion about the status of legal service providers. For example, consumers find it difficult to differentiate between solicitors, licensed conveyancers and barristers, let alone regulated and unregulated providers.

20. There is an increasingly bewildering array of types of legal service and products that are available; we touched on the burgeoning online offer earlier in this response. With consumers increasingly accessing products and services on the internet and becoming more comfortable with transactional relationships the response of the legal services market has been to become more brand based. Online legal services have become prominent and are advertised by 'super' practices that seek to attract more business through competitive, usually fixed price, costs. Access to boiler plate legal documents and the DIY attitude of consumers are also beginning to lead to a number of new challenges in regards to online dispute resolution (ODR).

EU Directive and the chance for a more strategic approach

21. In the UK there is a strong culture for resolving disputes through independent and impartial schemes, based on a sectoral approach, divided between public and private services and then by specialism of a professional or business sector. As a result consumers are able to receive different

[4] Economic research into regulatory restrictions in the legal profession, European Economic (Office of Fair Trading), November 2012

remedies from different schemes, as they have different formal powers. There is no encompassing strategy which binds redress together.

22. There are different levels of ADR, as there is no one-size-fits-all solution and depending on the level of dispute, different approaches may be appropriate. Ombudsman schemes sit alongside informal dispute mechanisms that can be provided by the industry (voluntary schemes). Both of these act as a counterpoint and alternative to the formal courts and tribunal process which mop up the complaints that are not able to be resolved through another sort of alternative dispute resolution mechanic. While they all aim for the same result, the remedies they are able to provide and their processes are very different from other consumer protection measures. There needs to be a greater level of co-ordination to ensure that the alternative structures for access to redress and dispute mediation sit neatly with the broader framework of courts and tribunals. Our view is that any approach to ADR would benefit from joined up working to promote greater co-ordination between ADR initiatives and other consumer law protections offered through the courts and tribunal system, as part of a broader strategic approach. A less segmented response to ADR is central to ensuring that consumers have access to a robust and comprehensive safety net and therefore can have confidence in ADR mechanisms overall.

23. The European Union (EU) research relating to their draft Directive on alternative dispute resolution (ADR) identified a number of weaknesses, which include gaps in coverage of ADR in some economic sectors and geographical levels, a lack of awareness and insufficient information preventing consumers and business from using ADR, and variable quality of ADR schemes. Without a more coherent approach there remains a risk of a race to the bottom in the offer of ADR to consumers.

24. Consumer confidence in the ability of ADR schemes to resolve disputes go beyond simply the absence of decision making. Our governance mechanisms as set out in the Legal Services Act 2007 are designed to ensure both independence of decision making as well as to ensure that the sector does not have control of funding arrangements and resourcing. There may be innovations which may allow ways of meeting the Ombudsman Association principles that give consumers better access to redress at less cost and better levels of efficiency.

25. Essentially a single set of rules common across ADR schemes would be simpler to communicate to traders and consumers, providing a consistent approach to complaint handling as well as being more straightforward to operate. Harmonisation within the legal sector too would also help to contribute towards simplification across sectors, as the advent of new forms of regulation, such as Alternative Business structures and the multidisciplinary traders it encourages will necessitate. The European Union proposals present a key opportunity to remodel the existing system of ADR to resolve existing overlaps, shortfalls and conflicts rather than increasing confusion for consumers accessing redress. If nothing else, a more coherent approach is required so as to avoid the dangers of poor quality and confusing access to ADR for consumers. Ideally,

there should be a more strategic look at the overall shape of redress to ensure it meets consumer need.

26. If you would like more information about the Office for Legal Complaints response then please contact Nicola Sinclair, Policy and Research Manager.

May 2013

Annex 1: Information about the Legal Ombudsman

The Legal Ombudsman (LeO) is the complaints handling body set up under the Legal Services Act 2007 as an independent ombudsman scheme to resolve complaints about lawyers in a fair and effective way.

The Legal Ombudsman launched its service in October 2010. Our vision is that everyone can access legal services with confidence. Part of our mission is to pass on what we learn from complaints to the legal profession and the wider sector to help enable people to access justice with more confidence.

Since opening, the Legal Ombudsman has continued to work with lawyers and consumer groups to improve standards of the legal profession and to feedback lessons learnt through our investigations. As part of this we have produced a number of guides for lawyers and consumers as well as developing CPD courses on complaint handling for the legal profession in early 2013. The courses focus on LeO's complaints process, first tier complaints handling and what we can learn from our data so far.

We have recently published a report around family law. It accounted for around 18% of the 7,500 or so complaints handled by the Legal Ombudsman in 2011-2012, making it the most complained about area of law. This new report aims to explore some of the issues that give rise to the higher levels of dissatisfaction in this area of law and look at how lawyers and consumers can prevent and respond to these issues.
Awareness of our service is also very important. The annual survey, which first took place in 2012, is designed to measure awareness levels of our service within the general public and users of legal services. The results are used to benchmark and track the impact of our communication and media activity and to report on LeO's newly agreed impact KPI. What we have found so far is that awareness levels have increased significantly over the last 12 months and media and television remains an important tool in commutating the services of the Legal Ombudsman across all demographic groups. Although there remain to be significant differences in awareness levels amongst the younger and older sectors of society and social grades, this is partly to be expected as the pattern reflects trends in use of the legal services more widely. While respondents generally had a positive view of the Legal Ombudsman, with the vast majority describing us as an independent body, the evidence suggests that there is some ongoing confusion about the cost of having a complaint investigated which may prove to be a barrier to accessing our services.

We aim to resolve complaints within 90 days and overall, more than seven in ten complaints (72%) are satisfied with the professional service provided by the Legal Ombudsman, whilst just under three in ten (28%) are dissatisfied, although it was noted that the satisfaction with the professional service is closely linked with satisfaction with case outcome.

Another of the ways we aim to do that is to feedback our experiences, insights and raise issues through responding to consultations such as this, and we welcome this opportunity.

Written evidence submitted by Della Reynolds (COM 20)

1. My route to PHSO came via the regulatory procedures which control higher education, so at least no-body died in my case. However, because of the systemic failure of PHSO to apply sanctions, all parties acted with arrogant impunity, safe in the knowledge that there was less than a 2% chance of censure. The Principal at the college where I studied told me that I could complain all I liked, it wouldn't get me anywhere. Clearly she knew how the system worked.

2. Like everyone else, my experience started with a deeply wounding trauma which caused me to lodge my original complaint at the privately funded higher education centre where I was about to complete my studies. Due to tutor weakness in marking and feedback compounded by an unprofessional internal verification procedure, I failed a significant part of my level 7 course. Whilst still struggling to come to term with my emotions, I had to deal with a complex and convoluted complaint system where there is no clear guidance and everything has to be requested and requested again.

3. My pathway took me through OCR as the awarding body and Ofqual as the regulator, but neither of these bodies listened honestly to my complaint and there was nothing to deter them from allowing the matter to escalate to PHSO. They were probably hoping that I would fall out of the system due to ill health as they were deliberately unhelpful and unnecessarily prolonged the process. It is only the survivors who manage to get as far as the Ombudsman.

4. In order to achieve any justice, distressed individuals are forced to rely on their own resources and do all the work. They must find the evidence (often with great difficulty as organisations close ranks), present the facts in a logical manner and pay all the costs of printing and postage. After a great deal of time and effort, this evidence is either denied or ignored by those in authority and asking for a review just rubber stamps the original findings as all reviews are carried out internally.

5. When you get as far as PHSO with the support of your M.P. it turns out that approximately 95% of complainants are turned away at the door and either sent back into the system that has just failed them or told simply that there is nothing more that can be done for them. PHSO takes action on approximately 4% of cases and finds in favour of just over 1% of total cases presented, so the odds are stacked against you.

6. PHSO strictly adhere to procedural policies such as telephoning each complainant when an investigation is taking place, presumably to be seen to be more client focused and sending out reply slips to a dedicated time span and consider that by following these procedures they are doing a 'good job'. Interestingly, none of their 'six customer service standards' looks at the quality of the service delivered. Under the misapprehension that the Ombudsman is transparent and accountable I telephoned the same helpful individual who had contacted me prior to the final decision to ask why he had dismissed 13 pages of evidence including the legal advice of a barrister who identified three breaches in procedure as 'mere opinion' but he quickly informed me that as the review was complete he could not discuss the matter further and then put the phone down. PHSO are the opposite of Ronseal, they do none of the things it says on the tin.

7. The Ombudsman's decision is final, no matter how irrational. They are able to take statistical and factual statements and determine that none of it is objective. Using the two weapons of deny or ignore they cut swaths through the evidence presented by the complainant whilst they accept at face value all statements made by service providers, even when there is no evidence to support their claims. In any other situation this would be called applying bias, but if challenged they use their 'get out of jail free' card and suggest you take the matter to judicial review.

8. When those who govern fail to protect those who are willing to be governed then the illusion of democracy is shattered. PHSO and in fact all of the Ombudsman services contribute year on year to converting thousands of citizens into disillusioned and disaffected individuals. Where there is no justice there can be no closure and the emotional damage is immeasurable.

9. The irony of the whole situation is that PHSO and others probably cover up wrong-doing in order to save money, but then the continual cover up costs more than correcting the original problem. Unfortunately, like a Faustian pact, once entered into there can be no turning back. What most people want when they complain is an acknowledgement, an apology and something to be done to improve the situation for themselves and others. This actually costs very little.

Suggested changes:

10. Those closest to the action should be most directly accountable. The primary organisation should have both incentives and deterrents to prevent complaints from escalating beyond their domain. It should cost them more financially if a complainant goes up to the next level and there

should be greater penalties applied at each stage. Distressed individuals need speedy justice.

11. Use the tools of social media to give users of services a voice. Each organisation must have a forum where clients can post both good and bad reviews. This information would feed into Quality Accounts along with customer service questionnaires. If you have ever shopped on e-bay you will know that sellers provide excellent service in order to maintain their star ratings. Time to bring government bodies into the real world alongside commercial providers.

12. Only a fraction of the cases should get as far as PHSO as the individual organisations improve their handling of complaints in order to avoid financial penalties and public disapproval. **All** cases received by the Ombudsman should then be **independently** investigated with heavy fines imposed in order to deter high pass-on rates. If PHSO fails to be **independent** and **impartial** at this stage then the whole regulatory system fails. There must be effective sanctions applied from above and PHSO should act as a feedback loop not a buffer zone.

13. PHSO satisfaction questionnaires should be provided to all complainants and the results published on their site. I have never been asked to review their services and I wonder where their data on customer satisfaction comes from. All complaints made against them should be reviewed by an independent moderator and the results fed back into their satisfaction ratings.

14. **A great deal has already been written and spoken with regard to deficiencies in the Ombudsman service, what we are all waiting for is some action.**

May 2013

Written evidence submitted by Mrs W Morris (COM 21)

1. Yes they do make a difference but the delay and slow , cumbersome processes limit the usefulness.

2. All Public bodies need robust, standardised initial complaint processes eg. a questionnaire type with immediate statistical analysis to identify trends or obvious areas of concern. The monthly analysis will alert local management and beyond, of trends eg. raised mortality which can be addressed swiftly, and action taken immediately.

3. Trusts etc will be legally bound to the procedure, given set standards of care, conduct that are part of the statistical questionnaire.

4. CQC will have responsibility for monitoring all data produced and the power to intervene, swiftly, in a set timeframe, if a Trust did not fulfil its legal obligations.

5. ONS can collate the data and use it for future costings and management purposes in Public bodies.

6. Ensure that whatever complaint process is in place, the complainant and body have equal access to data - that a Body has to send its 'complaints file' to the complainant to ensure veracity of source data without long, slow, FOIR which is the current process. (my experience is of two trusts lying to the Ombudsman who had no idea until I did an FOIR and proved the deceit. Until that point the Ombudsman had believed Trusts over complainant.)

7. Introduce the concept of witness statements as current complaints give over reliance on paper records, i.e. the Public Bodies with many records appear more believable than the complainant who is never interviewed.

8. Introduce accountability by adopting the standards of evidence for Courts - lying is perjury and punishable. Document tampering mad illegal(Recall the Hospital league table figures that were falsified with impunity)

9. Implement strict adherence to a code for complaints - that complainants cannot be blocked from legitimate complaint by the Body deeming them vexatious, without any recourse to contradict the edict. Impositions from Bodies who wish to silence serious complaints.

10. Cause Bodies to report statistics on how many live complaints they have, how long on the books etc - report stats to CQC like Ofsted monitor school exclusions etc. and let CQC have serious, swift sanctions.

The above are based upon my 5 .5 year struggle with 2 Trusts and the PHSO regarding the disgusting care received by my elderly Mother (unseen files claimed I was an Abuser and

only an FOI revealed the horror and allowed me to rectify the false Data passed between all 3 bodies as true. 2 have accepted they held false data - I had to invoke both FOI and DPA to get this far. After 5 years Sefton Council is still trying to claim it was not the source of the false data, despite the evidence. The complainant is reliant on using FOI and DPA, slow, time consuming, reliant on the Council accepting correspondence, which Sefton has declined to do. The cost to the tax payer cannot be justified but serious wrongdoing should be exposed.

May 2013

Written evidence submitted by T J Bartlett (COM 22)

Complaints: do they make a difference?

1. What objectives should Ministers adopt when considering how complaints about Government and about public services provided by Government are handled?
   - What gaps in the complaints systems exist; and how should ministers ensure they are addressed?

   Things can look very different when viewed from different perspectives. Senior civil servants may genuinely believe that their departments/agencies are doing a good job of dealing with complaints simply because those lower down the hierarchy have ticked off boxes as "resolved", while members of the public are left frustrated because genuine grievances have been stonewalled so persistently that they have been forced to give up.

   I suggest that no complaint can be regarded as "resolved" until the person who made the complaint is satisfied with the outcome. *Whilst this may mean that some complaints can never be resolved, it would be considerably better than the present system in which genuine grievances are ignored.*

   It is essential that departments and agencies should be given the chance to resolve disputes locally, but I suggest that ***local dispute resolution should be time-limited to prevent it from degenerating into a war of attrition****, in which the agency passes the complaint from one official to another until the complainant eventually gives up. I suggest that a complaint that is not resolved within 28 days should be automatically referred to an arbitrator.*

   It is unsatisfactory for the department, agency, or individual that is the subject of a complaint about to have the final say in whether a complaint is referred to the next level of resolution, or for it to be able to filter the evidence supplied to the outside assessor.

   "Independent" should mean independent*. A different person in the same office is cannot be described as "independent". A different person (or group of people) employed by the department or agency being complained about is unlikely to be independent. I suggest that it is questionable whether civil servants or former civil servants can be truly independent when dealing with complaints about other civil servants.*

2. How effectively do Government departments and public service providers use complaints to improve the service provided?

   Government departments and public service providers do not appear to use complaints to improve the service provided, and seem to have little or no incentive to do so.

   - Who should be accountable for leadership and governance of complaints systems across government and its agencies?

   No comment

   - How should data on complaints be gathered and monitored?

No comment

- How should information about complaints be used to lead and drive improvement?

No comment

- What do complaints cost; and how much money could be saved by learning from complaints?

I am submitting a separate document that refers to two complaints I have made that in the past five years that were eventually submitted to the Ombudsman. Both were all about money: in both cases, I am sure the officials concerned believe that by stonewalling my complaints they were "saving" public money.

In one case, it cost about £2000-worth of my time to defend myself against an unjustified demand for about £120. I doubt whether it cost the agency concerned any less. The case was eventually settled (in my favour) in court. It could have been resolved in a few seconds over the telephone

***The true cost of the stonewalling strategy is in public trust**. There is a limit to the number of times any individual can be expected to put up with arrogance and dishonesty from civil servants before they begin to believe that all (or most) civil servants are arrogant and dishonest and that dishonesty has been elevated to official policy.*

3. How quickly do complaints systems deal with legitimate grievances and provide redress?

They do not. The primary objectives of every complaints system I have encountered in government bodies have been to deny responsibility and avoid providing redress.

4. How easy is it to make a complaint about a Government department or agency, and how could this be improved?
    - Can people easily find their way around complaints systems?

No. Even if each individual step is clear, the procedure as a whole is not. Some officials seem to feel obliged to make it as difficult as possible to progress a complaint.

- Do complaints systems provide proper access for vulnerable, disengaged, or excluded groups?

I am grammar-school educated, a former Royal Navy officer, and now a journalist, so I regard myself as well-educated and literate. I have found dealing with government agencies to be difficult, time-consuming, and frustrating. How someone who is ill, frail, or has learning difficulties or a poor grasp of English would cope is unimaginable.

- How welcome are complaints to government departments and agencies, compared to complaints to a department store or to a mobile phone company for example? What should government learn from the private sector?

I do not believe any person or organisation welcomes complaints, but most private sector organisations recognise that when complaints arise, they are best dealt with

quickly and honestly. My experience of government agencies is the opposite: delays seem to be a deliberate strategy; mistakes are commonplace and deliberate misrepresentation is not unusual.

- Do complaints systems succeed in making public services and government departments more accountable and responsive to service users?

No. That does not seem to be their purpose (see 3, above)

5. Do complaints-handling systems achieve the right balance between non judicial and judicial investigations and remedies?
    - What is the right balance?

No. In my opinion, judicial investigation/remedy should be unnecessary in most cases: deliberate dishonesty should be extremely rare, and it should be possible to rectify genuine mistakes without recourse to the judicial system

- How can ministers reduce litigation costs and defensive behaviour in favour of informal redress and openness?

Sadly, I believe the culture of "defensive behaviour" has progressed to the stage at which institutional dishonesty has become widespread and deeply ingrained: I refer you to the case histories outlined in the attached document.

I feel very strongly that the only way this can be corrected is by taking rigorous disciplinary action against individuals who are found to be impeding the resolution of complaints.

6. How aware are service users of the various ombudsmen (such as the Local Government Ombudsman, Financial Ombudsman and the Housing Ombudsman)?
    - How do they coordinate their respective roles?

No comment

7. What lessons for complaints handling in the NHS are emerging from the Francis Report into failing at Mid Staffordshire Hospital?
    - Which lessons have relevance to complaints handling processes elsewhere in Government and public services?

No comment

8. How well do Ministers and senior officials deal with complaints raised by MPs on behalf of constituents?
    - What do Ministers and senior officials learn from complaints and how do they use complaints as feedback on departmental policy and implementation?

It probably varies from one department/agency to another, but my experience is that they do not "deal with complaints" at all.

I am submitting a separate document that refers to two complaints I have made that in the past five years that were eventually submitted to the Ombudsman. One of them involves a dispute with the DVLA, which was pursuing an unjustified demand for about

£120. The Independent Complaints assessor advised the DVLA to let the matter drop, but it refused to do so, and instead took me to court, where its claim was dismissed. That was in 2008-09. The same thing has happened to countless other people and has been covered in newspapers, on TV, and numerous internet forums, before and since, but it is still going on.

9. How should complaints about complaints systems be handled?
   - How should departments and government as a whole monitor performance of complaints handling systems?

No comment

   - Do tribunals systems work effectively; and how could they be improved?

No comment.

   - Should there be a single point of contact for impartial information on where to make a complaint or to seek redress? How should this be provided?

In a perfect world, a "one-stop" shop -- analogous to UCAS for handling applications to higher education or the 999 telephone number for contacting the emergency services -- would be ideal. But unless and until government departments and agencies learn to deal with complaints properly, it would be a wasted effort.

10. How do other countries handle complaints and what could the UK Government learn from them?

No comment

Parliament's Ombudsman Service

11. What should be the relationship between the Parliamentary and Health Service Ombudsman and;
    - The individual citizen?
    - Parliament?
    - The Public Administration Select Committee?

For many people, the Ombudsman is the final safety net to protect them against maladministration or deliberate wrong-doing by government officials. It should exercise that role responsibly, rather than treating complaints as a box-ticking exercise. It should certainly not be attempting to take on more complaints unless it is able and willing to investigate them properly, rather than finding excuses to dismiss them. The ombudsman's own figures show that less than 2% of complaints are investigated, and less than 1% are upheld.

***The chances of the Ombudsman actually investigating any individual complaint are about the same as the chance of winning a prize in the National lottery with a single ticket*.**

A "safety net" that allows more than 98% of cases to fall through it is not fit for purpose, and is probably beyond repair. It should be discarded, and an effective replacement introduced as soon as possible.

I am not qualified to comment on the Ombudsman's relationship with Parliament or the PASC, except that as the Ombudsman claims to have been "... set up by Parliament to help both individuals and the public.", it has a duty to Parliament to do what it was set up to do. I am sure a postman who dumped 98% of letters in the bin, or a bus driver who drove past 98% of his bus stops without stopping would soon find themselves looking for new jobs. I see no reason why the Ombudsman should continue to receive taxpayers' money for doing less than 2% of the job.

12. How effective is the Parliamentary and Health Service Ombudsman as a service for handling complaints that have not been adequately dealt with elsewhere?

Useless. It is an exercise in whitewashing.

- How should complaints about the Parliamentary and Health Service Ombudsman be handled? How effectively does the Parliamentary and Health Service Ombudsman deal with complaints?

In my experience, the PHSO does not deal with complaints about itself.

I am submitting a separate document that refers to two complaints I have made that in the past five years that were eventually submitted to the Ombudsman. One of them was initially rejected but subsequently reviewed. The letter I received after the review showed that the fundamental point of my complaint had (again) been completely missed, but the concluding sentences were ***"This review is the end of the complaints process, and it is time to draw correspondence on your complaint to a close. We will acknowledge anything more you send us about it, but will only respond if we see a need to."***

Like most "customers" who have felt it necessary to ask the PHSO to review an unsatisfactory decision, I remain very dissatisfied with the outcome. The PHSO's own research[1] shows that in 2010-2011 62% of complainants whose cases were reviewed were "dissatisfied" or "very dissatisfied" with the service.

13. Should citizens have direct access to the Parliamentary and Health Service Ombudsman for all complaints, as people already have in respect of complaints about the NHS?

No. Such a move would probably make the Ombudsman's annual report look more impressive by increasing the number of complaints submitted, but it is difficult to imagine that it would increase the number that are investigated and upheld. It would serve no useful purpose.

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[1] http://www.ombudsman.org.uk/improving-public-service/research/customer-satisfaction-research-may-2010-april-2011/6

Statement

14. Thank you for inviting evidence from members of the public.

15. I appreciate that the Public Administration Select Committee cannot investigate specific complaints, but I believe that specific case histories will provide more useful information than general comments.

16. Although my comments relate to my personal experiences, I have no reason to believe that I am a special case: indeed, news reports and web forums suggest that my experiences are common. Similarly, although my detailed comments relate to just two government bodies, experience suggests that similar attitudes are widespread.

Key points

17. In some government departments/agencies/trusts etc. there is a marked reluctance to accept the possibility of error, sometimes stretching to outright dishonesty.

18. There are obvious financial incentives for government bodies to evade their obligations and/or demand money from members of the public, with few (if any) balancing incentives for them to take complaints or appeals seriously.

19. Official correspondence is often patronising and/or threatening.

20. Internal complaint procedures may be disproportionately complicated or long-winded -- apparently intended to discourage complaints or to encourage complainants to give up.

21. So-called "independent" dispute resolution procedures are neither independent nor impartial, and even if they find in favour of the appellant, their powers are limited and their recommendations easily ignored.

22. The PHSO investigates only a tiny proportion of cases, and seems to be easily bamboozled by procedural smokescreens and technical jargon. It gives the illusion of acting as a safety net, but really serves to cover-up maladministration and dishonesty with a cloak of false impartiality.

The chances of the Ombudsman actually investigating any individual complaint are about the same as the chance of winning a prize in the National lottery with a single ticket.

23. The legal system provides little practical protection against wrongdoing by government bodies. Few private individuals can afford to take on an opponent to whom the odd £10,000 (or even £100,000) won't even show up in the executive summary of the year's accounts.

24. I strongly believe that officials involved in dishonesty (as opposed to error) should face immediate dismissal and possible prosecution for fraud. If it were rigorously

enforced, this would encourage openness and honesty, making it easier to resolve complaints quickly and economically.

Case History 1: DVLA

25. In January 2008, I part-exchanged a car, and sent all the paperwork to DVLA.

26. About four months later, I received a letter from DVLA claiming arrears of tax on the car that I no longer owned, and demanding a penalty for late payment.

27. DVLA subsequently accepted that I had disposed of the vehicle, and dropped its claim for "arrears" of tax, but persisted in demanding the penalty.

28. The matter was eventually referred to the Independent Complaints Assessor (ICA) who recommended that DVLA should let the matter drop.

29. DVLA ignored the ICA, and took the matter to court in February 2009.

30. DVLA's case was dismissed

31. DVLA has offered no apology and has refused to compensate me for the time it wasted.

32. My MP referred the matter to the Ombudsman, but the Ombudsman refused to investigate it.

33. DVLA insisted that its actions were not a mistake[2]. They must therefore have been deliberate. Making a false representation with the intention of causing another to suffer loss is a serious criminal offence[3], so I referred the matter to the police.

34. The police refused to pursue the case, but suggested that I should refer it to the Ombudsman (!)

Comments on Case History 1

35. **It beggars belief that anyone might imagine that they could have a legitimate claim for a late payment penalty in respect of money that was never owed in the first place.**

36. This probably started as a simple error involving a slip of grubby paper[4] going astray.

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[2] DVLA repeatedly asserted that there is a legal obligation on an owner to contact DVLA if he/she does not receive an acknowledgement from DVLA after notifying the agency of a change of "keeper", when no such obligation exists.

[3] Fraud Act 2006

[4] The DVLA "Notification of sale or transfer" document is pale beige in colour, 20.8cm x 8.4cm: i.e. about a quarter of a sheet of A4.

37. If a long-standing customer of a private company appeared to have missed a regular payment, I believe most companies would send a polite reminder. The DVLA's first move was to accuse me of breaking the law and to demand a penalty. It was aggressive offensive, and provocative.

38. When I telephoned the DVLA, no-one seemed interested in resolving the problem: they just wanted money. When I asked to speak to the manager, the call handler hung up on me in mid sentence.

39. If I had been overcharged by a supermarket checkout operator, I would expect the problem to be dealt with on the spot, and without question. I would not expect to be threatened with legal action, or required to "appeal" in writing to the company's head office.

40. As my complaint moved up through the hierarchy, I faced:
    - the same "we never make mistakes" attitude repeated at every level (up to and including the Chief Executive).
    - individuals who attempted to stall the complaints process by refusing to supply the contact details of their superiors
    - avoidable delays, such as using second-class post to respond to emails
    - misrepresentation of facts (eg footnote 1)
    - patronising and arrogant attitudes, such as:
      - one middle-level official wrote *"I appreciate that it can be upsetting to be penalised by the law, but the Agency cannot ignore the legal requirements*". As it was already obvious that the DVLA claim against me had no foundation in law, I found this particularly offensive.

41. Dealing with DVLA was like Heracles' fight with the Hydra: when one official ran out of excuses, another one took over to repeat them. We wasted ten months and about £2000-worth of my time arguing over £80. The policy seemed to be that "if we stonewall for long enough, the complainant will just give in".

42. There were signs of bias in the Independent Complaints Assessor's report, such as:
    - The tenor of her report treats all my statements as questionable (even when supported by documentary evidence), but accepted unsupported DVLA statements as incontrovertible.
    - She accepted DVLA's assertion that *"...it is impossible to distinguish the honest customers from the many thousands who claim that they have posted the relevant information to them but have not... "*, without commenting on the validity of the presumption of guilt that follows from it.:
    - She praises the DVLA for providing "courteous, informative and prompt replies" despite evidence of :-
      - the "presumption of guilt" (see above);
      - misleading information
      - persistent "stonewalling" and delays

43. Although she recommended that the DVLA should abandon its efforts to get me to pay the LLP, the ICA added that she was *"...aware that the DVLA is unlikely to agree*".

- She was quite correct: the DVLA ignored her recommendation, and took me to court.

44. The Ombudsman refused to investigate it the matter on the grounds that "the matter had already been decided in court".
    - My complaint was never "decided in court", because the case was brought by the DVLA, who had not asked the court to rule on whether it should offer me an apology and/or compensation.
    - The Ombudsman's policy of not investigating cases that have "already been decided in court" means that DVLA was able to isolate itself from the possibility of investigation, simply by bringing a frivolous case, for the minimal price of a court fee.
    - By encouraging the DVLA to bring such frivolous cases, the Ombudsman increases the risk that innocent motorists will give in to the DVLA's bluff, and pay up rather than stand up to the agency in court.

45. The police refused to pursue the case on the grounds that although DVLA staff had made misrepresentations and that the intention was to collect money from me, they considered that it would be difficult to prove criminal intent. The Detective Chief Inspector who dealt with my case wrote *"It is clear from your research that there is cause for complaint in relation to the manner in which the DVLA have treated you as an individual and the issues you raise with their internal performance policies. I understand from our conversations that you have raised the first with the ombudsman to no avail, it is the advice of our legal department that you raise the latter as a complaint presenting the research material you shared with us."*

Case History 2: Primary Care Trust

46. This complaint concerns the funding of long-term care. I appreciate that this is a difficult and sensitive matter, but my complaint is not about the rights or wrongs of government policy: it is solely concerned with whether the policy was properly carried out.

47. In September 2009, my father suffered a severe stroke, and was admitted to hospital. By December 2009, it was clear that he would need on-going nursing care.

48. In January 2010 the Primary Care Trust (PCT) wrote that it would not fund my father's nursing care.

49. The case has been subjected to an on-going[5] appeals process, including a so-called "independent" review by the Strategic Health Authority (SHA)

[5] Although this matter has already been investigated by the PHSO, the PCT has issued several subsequent decisions covering different periods of time, each of which is the subject of a completely separate appeal.

50. In September 2011, I referred the matter to the Parliamentary and Health Service Ombudsman (PHSO).

51. On 9 March, the PHSO wrote that it would not consider my complaint against the PCT and SHA on the grounds that it has already been reviewed by the SHA and that the SHA had *"appropriately considered the National Framework and reached reasonable conclusions"*

52. In October 2012, the PHSO agreed to review its decision, but again did not uphold my complaint.

Comments on Case History 2: Technical background

53. The procedures governing Continuing Healthcare funding are laid down in the **National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care** (The National Framework) and **NHS Continuing Healthcare Practice Guidance** (Practice Guidance).

54. The National Framework requires that the patient's needs must be assessed by a Multi Disciplinary Team (MDT). MDTs fulfil that function by completing a document known as a Decision Support Tool (DST)

55. I eventually obtained a copy of the original DST that had been completed by the MDT in respect of my father. It differed in several key respects from the version that had been sent to me by the PCT. In particular the conclusion reached by the MDT was:

*"... Mr *** needs demonstrate a primary healthcare need and a nursing home placement should be fully funded under continuing health care."*

56. From the DST, the National Framework, and Practice Guidance it is very clear that:
    - The MDT recommended that my father should receive CHC funding
    - a PCT must not reject an MDT's recommendation[6]
    - a PCT must not rewrite an MDT's report[7]

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[6] The National Framework paras 80-81:

80. Many PCT's use a panel to ensure consistency and quality of decision-making. However a panel should not fulfil a gate-keeping function and nor should it be used as a financial monitor. Only in exceptional circumstances and for clearly articulated reasons, should the multidisciplinary team's recommendations not be followed.

81. PCTs should not refer a case back or decide not to accept a recommendation simply because the multidisciplinary team has made a recommendation that differs from the one that those who are involved in making the final decision would have made, based on the same evidence.

[7] The Practice Guidance para 9.2:

9.2 ... PCT decision-making processes should not have the function of:
- financial gatekeeping
- completing/altering DSTs
- overturning recommendations (although they can refer cases back to an MDT for further work in certain circumstances – see below).

57. By rewriting the MDT's report and rejecting its recommendation, the PCT disobeyed the explicit instructions that had been issued by the Department of Health in the National Framework and Practice Guidance.

58. The PCT admitted in several letters that it had overturned the recommendation of the MDT, and that it was not unusual for it to do so. For instance:
*"While NHS *** would desire to be able to ratify all recommendations made by Multi Disciplinary Teams (MDT) in relation to eligibility for NHS Funded Continuing Healthcare. The complexity of the process and the vast numbers of practitioners engaged in the process mean that this is not always possible."*[8]

Comments on Case History 2: The complaints process

59. The PCT persistently ignored the fundamental point of my complaint -- that the Department of Health explicitly directs PCTs **not** to reject the recommendation of MDTs.

60. The "Local Resolution" process began in January 2010. The matter did not move up to the SHA until June 2011.

61. The SHA review panel also ignored the fact that the Department of Health explicitly directs PCTs **not** to reject the recommendation of MDTs.

62. Reports of meetings produced by the PCT and SHA invariably include words to the effect of *"we properly considered the requirements of the National Framework"*. This is demonstrably untrue (see " Technical background to Case History 2", above).

63. Even when the relevant paragraphs of the National Framework have been quoted in correspondence, read out to them over the phone, or handed to them across a desk, PCT/SHA representatives simply refuse to look or listen to them.

64. The appeals process is heavily biassed:
    - the PCT panels are selected by the PCT
    - dates and venues are chosen by the PCT
    - in one instance I was offered two possible dates for an appeal hearing. One of them was while I was due to be away on business abroad. The panel on the only alternative date included one person who had been a member of the panel whose decision was the subject of the appeal!
    - the so-called "independent" review panel was appointed by the Strategic Health Authority and was dominated by NHS staff.
    - Minutes of panels are taken by members of PCT or SHA staff, and are often garbled to such an extent that they misrepresent what was actually said. At one meeting, when I produced a dictating machine to keep an accurate record of proceedings, the chairman immediately stopped the meeting.

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[8] Letter from PCT dated 12 July 2010

The role of the Ombudsman

65. I understand that the role of the Ombudsman is the subject of a separate investigation by the select committee, to which I also intend to give a statement.

66. A key point of my statement will be that (according to the Ombudsman's own figures)
    - **Less than 2% of all complaints were actually investigated**
    - **Less than 1% of complaints were fully upheld.**

67. Despite its assertion that "*Our role is to investigate complaints*", and "*We work to put things right*", its own figures show that the Ombudsman's office fails to investigate complaints and does virtually nothing to put things right.

68. While the odds are so heavily stacked in favour of government departments and agencies, the Ombudsman's office is counterproductive. It gives the illusion of being an independent arbiter, but by rejecting so many complaints it gives tacit approval to ongoing malpractice.

69. It is sometimes suggested that Judicial Review is an appropriate avenue for those who are not satisfied with the outcome of a complaint to the Ombudsman. Few private individuals can afford to take on an opponent for whom the odd £10,000 won't even show up in the executive summary of the year's accounts, so in my opinion, this suggestion is either naive or deliberately offensive.

Conclusions

70. Many officials are extremely reluctant to admit the possibility of error. This may lead to a mistaken but self-perpetuating belief that anyone who complains is doing so for dishonest reasons.

71. In some cases, the reluctance to accept the truth stretches to blatant dishonesty.

72. Dealing with some government departments is like fighting a war of attrition, in which the policy seems to be "if we stonewall for long enough, the complainant will give in"

73. Not all officials are quite as blatant as the one who told the ICA that *"...it is impossible to distinguish the honest customers from the many thousands who claim that they have posted the relevant information to them but have not... ",* but his "presumption of guilt" is all too common.

74. The financial incentives that drove the actions of the DVLA and PCT in my case histories are obvious. There are no balancing incentives for them to take complaints or appeals seriously.

75. So-called "independent" reviews may be independent in name only.

- The so-called "Independent Review Panel" in case history 2 was dominated by NHS employees.
- The Independent Complaints Assessor correctly predicted that the DVLA would ignore her recommendation, so her intervention served no useful purpose.
- The Ombudsman investigates only a tiny proportion of cases, and seems to be easily (perhaps willingly?) bamboozled by procedural smokescreens and technical jargon.
- The legal system provides very little protection against wrong-doing by government bodies. It is inappropriate for minor disputes and is difficult, time-consuming and expensive for major ones.

76. In both my case histories, representatives of the agencies concerned reacted to complaints/appeals by deliberately misrepresenting facts, with the intention either of obtaining or withholding money. If any private individual did this, they would be guilty of fraud.[9] If they acted with the consent or connivance of senior management, then the manager and the company would also be guilty of fraud.
    - Officials involved should face immediate dismissal.
    - I believe the police should be encouraged to investigate and take the same enforcement action against civil servants as they would against any other fraudsters.

77. The Independent Complaints Assessor and Ombudsman are notionally independent, but it is clear that they have far more empathy with the civil servants they are supposed to be investigating than with the members of the public they are supposed to be protecting.

May 2013

9 The definition of fraud does not specify that the perpetrator has to benefit from the misrepresentation: the acid test is whether the intention is that the victim suffers loss.

Written evidence submitted by C N Rock (COM 23)

I wish to provide views on complaints handling as experienced in an NHS case.

Background

Experiences:

- Firstly—while our son was suffering from mental illness: we complained verbally that he wasn't getting proper attention and support. 'Patient confidentiality' was used as reason to do nothing instead of extending co-operation. A written complaint was made, a month before my son died.

- Secondly—after our son's suicide: we tried to get understanding and redress of collective NHS failures, using 'NHS complaints procedure'; to no avail.

Events relating to complaints experience:

a) We complained verbally on different occasions over 5 years. I don't think these were regarded as complaints but we were saying we were *dissatisfied with the state of affairs: our son was visibly deteriorating and nobody would help.*

b) These actions in themselves had no useful outcome. We had to bypass the GP to get her to act. This did not trigger any enduring attention or cooperation, and actions were counterproductive by distancing my son from medical attention.

c) It took nearly 4 years to 'win' a second intervention—requests in-between had been ignored. The careless outcome of that episode compounded problems already experienced.

d) Four months later I complained again verbally—to GP; ignored. Three months later I complained and said I was going to make a written complaint—to Trust; ignored. I approached my MP to help with the dilemma. Our son was being left to 'die', tortured within himself, with no help.

e) It was unclear where to direct complaint as both GP and Trust had behaved harmfully and negligently. We had no previous experience complaining to NHS; we trusted what we were told was accurate and informed.

f) I complained in writing to the Mental Health Trust, but received an ambiguous response of no urgency. Their problem again was 'patient confidentiality', though *they knew our son was without capacity.*

g) While the complaint was in this delayed process, our son took his own life.

h) Subsequently, GP, NHS Trust and Ombudsman (PHSO) were wholly incompetent in appreciating the catalogue of failures facilitating our son's death.

i) The Trust could not 'investigate' the GP, and the GP was unable or unwilling to investigate herself. The Practice manager—effectively a GP employee—had no influence or duty to implement this: the actual response I received was specious and un-researched. The contracting PCT declared disinterest.

j) Dealing with the PHSO resulted in much time-wasting and *additional personal burden* getting nowhere. It was rejected because 'they [NHS] appear to have responded fairly" to the complaint'. An appeal, misapplied by the PHSO as an 'internal review of process', was unsuccessful.

k) We had to take legal action to try to get acceptance and redress for mistakes made; not that it would ever put things right for us having lost a son who had needed help six years before. 'Professionals' negligently had in-effect assisted in his suicide. We saw it happening.

l) Even then, actions were only partly satisfactory due to careless investigation; lack of questioning and comparison of records; bad record keeping in general; and disjointed nature of Services, not challenging each other's evidence.

Comment on Complaints questions 1-9 in Issues Paper

Comments are only in areas of experience; but include issues raised in the light of other recent service failures and *to which I can relate personally.*

1.a Objectives (and Principles) are probably well defined—readily quoted and eagerly publicised by those services. Service representatives appeared incapable of realising those objectives; promoted as top-level aspirations but not understood or carried out; *not even followed at highest complaint level, in the case of the PHSO.*

1.b Ministers need to scrutinise existing systems for <u>meaningful response and outcome</u> (complaints departments, internal examiners, PHSO, Monitor, CQC). The PHSO enquiry will be welcomed: however there <u>must be a review of failures</u> or the exercise is pointless.

2.a Perhaps monitoring all complaints should fall to an existing body such as Monitor. The cost of failure is a well-documented issue. It must drive transparent learning from mistakes, and keep up pressure for better first-time experience.

2.b Professional bodies should be *obliged* to be involved in the accomplishment of investigations. A recent FOI (freedom of information) request to the GMC showed that basic statistics with regard to complaints after patient death, per GP, were not kept.

3.a Ignored verbal complaints, which should have indicated seriousness of developing issues, were wasted opportunities to take early action.

3.b Written complaint failed due to lack of appreciation of urgency. Paper-handling formalities prevented immediate response. The patient confidentiality issue was inappropriately applied due to bad communications and misconceptions—it should never have influenced this stage: Services were already aware of problems.

3.c Afterwards, in complaint, I did not see issues dealt with comprehensively or honestly, even by senior members. I applied to the PHSO for redress in this matter. I could not believe that with all the trouble; years trying to get help, which our son duly deserved—yes, as a Right—the case of his death would not be investigated assiduously. We were let down again: the PHSO never investigated and never apologised for a disgraceful response. Those involved escaped, scot-free—nothing to learn.

4.a Despite the simplistic openness surrounding 'making a complaint' it is not made easy. The complainant feels 'in the wrong'; other practitioners are reluctant to get involved; complainants may fear 'reprisal' in later attention, or removal from patient list, especially if 'explaining' isn't enough and practitioners take exception.

4.b I would also say that complaints (in the NHS) are treated without astuteness and as a tedium. Skill, acuity and independence was seriously lacking in investigation. Emphasis was on *explaining-away,* conveying a sense of protectionism rather than finding solution.

4.c In our case our son *was vulnerable*, in that he was without capacity in appreciating his illness. I was not 'allowed' to complain on his behalf although *services had seen he didn't understand his illness* and would not invite attention. He was 'disengaged' by those who should have helped.

4.d I tried getting help through the only channels I knew, but with my lay knowledge, was rebuffed. *Laws, guidelines and recommendations for this scenario* were in place, but practitioners 'had their own ideas' and were not prepared to enlighten us with their *obligations*.

5.a The assumption that a complaint has been '*resolved*' by Practitioner, Service or Ombudsman should not prevail, when questions remain unanswered. Plaintiffs should have the opportunity of 'signing-off' their complaint as having had satisfactory outcomes; and consequences reported back.

5.b There must be a *duty of candour* placed on practitioners and service operators without which redress can't be achieved, with legal *onus* on Services to co-operate in resolution. Litigation will and must always be a fall-back for failing services if the provider cannot deal with them 'in-house'.

6 Services appear too ready to inform of the 'Ombudsman option' in publicising their so-called 'fairness': referral to the Ombudsman is seen as a 'get-out' clause for Services *after giving a slack or knowingly ambiguous response to a complaint. Statistically, the odds are that the PHSO will take no corrective action—and they know it.*

7 'Handling Processes' do not need to be re-defined: they need to be implemented. Services could adopt ready-available British Standards Institute (BSI) or other proven process. This might be a step towards openness using existing independent bodies.

8 I did not feel that complaints via my MP were reaching further parts necessary for proper recognition and action within Government, considering the severity of failure.

9.a There appears to be no complaint system for complaint systems. The Ombudsman should be the actor in this, and yet there is no process within or beyond this step: the PHSO process incorporates, and builds-on, the errors of first responses, apparently without intelligent questioning—certainly in our case. An independent complaints handling authority should include and manage this process.

9.b Complaints and their investigation should follow standard procedures for each different management unit (e.g. within Health services: Trusts, Clinical Commissioning Groups, GPs, Health contractors). Services self-assessment is unreliable. Again, a BSI approach might work.

9.c A single-point contact for complaints might help (we did not know where to complain for combined service failures), but it can't be permitted to introduce delay, and must have independence and power to act.

Summary:

Delivery of fairness:

I did not find any aspect of my complaint being handled fairly. My first written NHS complaint was stalled. My son died as a result of bad practices in many departments. The PHSO response was incorrect, inappropriate, ambiguous and provocative. Injustices were never understood or dealt with.

Delivery of redress, and justice for people who complain:

No decisive actions were taken to address problems after the complaint, or after the initial outcome (my son's death). I had to research, chase and readdress problems to get a response. The GP was perverse before and after the event—essentially the crux of the problem; ignored symptoms; ignored the complaint; had no transparent complaint handling. No fair, complete redress or justice has been seen—now over four years on.

Admittance, action, *apology* and *follow-up* must be an essential part of redress. After death or serious outcome, a meaningful *report-back* should be automatic, reaffirming any corrective action. There should be defined feedback responsibilities for services to report success in changes made e.g. 12 months onward.

My enduring impression is that no complaints that we made were ever taken seriously enough, nor made any material difference to the awful support and advice we had. We lost our son because of this; then trying to get redress was a difficult and despairing task—incomplete to this date.

To examine how departments and agencies use complaints as a source of information and challenge, to improve the delivery of public services:

I have had no information to say whether my complaint handling experiences have been shared and communicated to other departments or services. I am told internal changes have been made in the Trust's department, but have not been advised of any effort in other services (e.g. GPs; Social Services) which failed, in my view, and another area of action missed by the PHSO.

Our inquiry will also look at how ministers and officials handle complaints made by MPs on behalf of their constituents:

I requested that my MP handle only some PHSO communications. I did not see that concerns were raised elsewhere, where her input might have been advantageous. For instance, no related concerns were raised in Parliamentary debate, as far as I know.

May 2013

Written evidence submitted by Alison Pope (COM 24) (N.H.S. related complaint)

1. What objectives should Ministers adopt when considering how complaints about Government and about public services provided by Government are handled?
Ensure that the investigation is handles with impartiality and without bias.

What gaps in the complaints systems exist; and how should ministers ensure they are addressed?
There is insufficient opportunity for complainants to question decisions.

2. How effectively do Government departments and public service providers use complaints to improve the service provided?
Completely ineffective.

Who should be accountable for leadership and governance of complaints systems across government and its agencies?
Government Minister responsible for specific departments of agencies, e.g. the Health Secretary – department of Health.

How should data on complaints be gathered and monitored?
Independently and without warning or notice.

How should information about complaints be used to lead and drive improvement?
Look closely at the number of complaints that are not fully investigated (by the Health Service Ombudsman)

What do complaints cost; and how much money could be saved by learning from complaints?
The process is too long and unwieldy!

3. How quickly do complaints systems deal with legitimate grievances and provide redress?
The complaints system does not recognise legitimate grievances or provide redress. The evidence of the complainant is given no credence.

4. How easy is it to make a complaint about a Government department or agency, and how could this be improved?
Extremely difficult. The system protects the entity being complained about.

Can people easily find their way around complaints systems?
No.

Do complaints systems provide proper access for vulnerable, disengaged, or excluded groups?
No. P.A.L.S. is not independent of the Health Service. I found S.E.A.P. through my own research.

How welcome are complaints to government departments and agencies, compared to complaints to a department store or to a mobile phone company for example? What should government learn from the private sector?
Listen to the 'customer' rather than defend the department or agency that is the subject of the complaint.

Do complaints systems succeed in making public services and government departments more accountable and responsive to service users?
No. My experience has been that the process was manipulated by the local health authority and that the ombudsman's department merely 'rubber-stamped' this position.

5. Do complaints-handling systems achieve the right balance between non judicial and judicial investigations and remedies?
No.

What is the right balance?
Provide a free means by which complainants can challenge the findings of the ombudsman's office either before the process moves to judicial review, or during this stage.

How can ministers reduce litigation costs and defensive behaviour in favour of informal redress and openness?
Give true weight and value to the evidence of complainants and ensure health authorities are truthful and do not 'hide behind' the workings of the complaints process.

6. How aware are service users of the various ombudsmen (such as the Local Government Ombudsman, Financial Ombudsman and the Housing Ombudsman)?
There is awareness, but also a lack of faith or trust in the ability of ombudsmen to act without bias or impartially.

How do they coordinate their respective roles?
I no experience of this being a factor.

7. What lessons for complaints handling in the NHS are emerging from the Francis Report into failing at Mid Staffordshire Hospital?
The complaints process needs to take proper account of the concerns raised by complainants, rather than defend the local health authority against which the complaint is lodged.

Which lessons have relevance to complaints handling processes elsewhere in Government and public services?
The complaints process needs to take proper account of the concerns raised by complainants rather than defend the local health authority against which the complaint is lodged.

8. How well do Ministers and senior officials deal with complaints raised by MPs on behalf of constituents? No apparent power to act on behalf of constituents. What do Ministers and

senior officials learn from complaints and how do they use complaints as feedback on departmental policy and implementation?
As an outsider, I cannot comment on this

9. How should complaints about complaints systems be handled? How should departments and government as a whole monitor performance of complaints handling systems?
Entirely randomly look at a sample of investigated complaints.

Do tribunals systems work effectively; and how could they be improved?
I have no experience of this.

Should there be a single point of contact for impartial information on where to make a complaint or to seek redress? How should this be provided?
Yes – clearly on all websites or publications linked to or available regarding the complaints process.

10. How do other countries handle complaints and what could the UK Government learn from them?
No knowledge of this.

Parliament's Ombudsman Service

11. What should be the relationship between the Parliamentary and Health Service Ombudsman and; The individual citizen?
Total accountability. Independent of ALL health authorities.

Parliament?
Totally accountable and answerable to Parliament before judicial review stage on specific cases.
The Public Administration Select Committee?
Totally accountable and answerable to P.A.S.C. before judicial review stage on specific cases.

12. How effective is the Parliamentary and Health Service Ombudsman as a service for handling complaints that have not been adequately dealt with elsewhere?
Completely ineffectual. Merely 'rubber stamps' the health authority's own investigation.

How should complaints about the Parliamentary and Health Service Ombudsman be handled? How effectively does the Parliamentary and Health Service Ombudsman deal with complaints?
By a specific department before judicial review stage.

13. Should citizens have direct access to the Parliamentary and Health Service Ombudsman for all complaints, as people already have in respect of complaints about the NHS?
Yes.

What should the relationship between the Parliamentary and Health Service Ombudsman and MPs be and how can it best work?
There should be a separate Health Service Ombudsman – two roles assigned to one ombudsman is illogical.

What is the link between Parliament and the Health Service? Could the Parliamentary and Health Service Ombudsman do more to support MPs handling of complaints on behalf of constituents?
The ombudsman needs to be able to explain exactly why individual cases are not investigated. Credence also needs to be given to the evidence presented by complainants, rather than relying solely on records kept by practitioners within health authorities.

May 2013

Written evidence submitted by Alan Reid (COM 25)

Parliament's Ombudsman Service

Submission to the Public Administration Select Committee

1. I welcome the opportunity to make a full submission, as a follow-up to my evidence prior to the annual oral hearing of the Ombudsman in December 2012, based on the 'story so far' of my complaint. In the present submission, I use the terminology 'Ombudsman' or 'PHSO' rather than the title given to this enquiry. Although I am critical of the whole set-up, I recognise that the MP *did* forward my case to the Ombudsman, and that the Ombudsman *did* finally secure for me an apology from the UK Border Force.

Summary

- Parliament, through the PASC, has let its Ombudsman become a defensive and bureaucratic body, more concerned with procedures than outcomes,
- The Ombudsman should cease to be an officer of Parliament, and become independent,
- The Ombudsman's vaunted transparency only covers explaining why it would *not* do a 'formal investigation',
- The Ombudsman should confine itself to cases where a department's procedures have been exhausted, rather than also being a multilingual public sector agony aunt,
- In any event, the 'MP filter' should be done away with; the leaving of an option of going through an MP is unworkable,
- So long as the 'MP filter' exists, which presupposes that MPs sometimes do refuse to forward a valid complaint (or that they simply drag their feet), there should be a recognised appeal procedure against an MP's negative decision (or lack of decision),
- Also so long as the MP 'filter' exists, there should be clarity as to whether complainants *must* go through their constituency MP, as opposed to another MP whom they know, and whether complainants without a vote in the UK *must* go through the MP chairman of the PASC,
- So long as the 'filter' exists, the MP chairman of the PASC should be given resources to acknowledge all submitted complaints from persons without a vote in the UK,
- Complaints about the *level of service* of the Ombudsman during the complaint should not be entirely dealt with in-house; there should be the possibility of turning to an Independent Assessor,
- While there should be no appeal against a decision of the Ombudsman (except for recourse to the courts), the final letter should always spell out the possibility of a

further review of the *handling* of the case; in consequence, this letter should be addressed to the complainant, with a copy to the MP, not the other way round.

Background

2. My complaint against the oral replies of the UK Border Force at Brussels and at St Pancras International, and then against the written reply of the UK Border Force in Dover, was described in my earlier evidence. I had made no complaints against the officers, who replied to me spontaneously, and who provided the written complaints procedure. However, I did rather object to having to write to the 'Customer Services Unit', as if I had the choice of taking my custom to another border police force.

The MP 'filter', including for complainants not on the UK electoral register

3. I do not have a constituency MP (because I have resided outside the UK for too long). I therefore enquired of the PHSO by e-mail what to do if the final reply from the UK Border Force was not satisfactory. The PHSO reply was confusing as to whether one could go through *any* MP, or only the constituency MP. In the case of complainants living outside the UK, the wording implied they could only go though Mr Jenkin MP (as chairman of the PASC). The PASC background note for this enquiry also refers both to "*an* MP" and to "*their* MP". Parliament and its officers should bring clarity here.

4. Of course, this problem would go away if what is now being described as the 'MP filter' was done away with. Compared to 1967, the situation both inside and outside the House of Commons is very different. The only MP I had met by 1967 was a Labour university lecturer in politics who was totally disillusioned, complaining all he did was deal with "Mrs McGinty's drains". My Scottish Conservative constituency MP regarded the House of Commons as his London club. One can see how the idea of offloading complaints from constituents on to an Ombudsman would appeal to both extremes.

5. Having resided outside the UK for many years, I had not realised that complaints against the NHS do not need to go through an MP, which I found curious for the most-politicised part of the UK public sector. Perhaps the next most-politicised part of the public sector is the UK Border Force and the UK Border Agency (now within the Home Office), yet for this we have to go through an MP.

6. The arguments for retaining the 'MP filter' seem to rest on a rather idealised view of MPs' relationships with their constituents. Most people do not know who their MP is (80 %?). People move residence between elections. Many will have never voted for their MP, given the UK electoral system, and may be disinclined to go to the 'opposition'. Some may know another MP better, through circumstances. Then people get 'disenfranchised' for weeks when there are by-elections and general elections, and a new MP has to recruit staff and learn the

ropes. There must be nagging doubts about whether, or when, a certain MP will deal with a case, because of some highly-publicised activity which clearly impinges on their 'day job', or because the MP is an important Minister, or simply because of the many recesses when people are not sure if the MP is around. Others might wonder if the MP would indeed forward the case, because the complaint fortuitously goes against that MP's known political agenda, or sponsors.

7. Another side to the MP 'filter' is that the final letter from the Ombudsman goes to the MP, with a copy to the complainant 'for information'. Maybe I am being over-sensitive, but this does give the impression that the affair is between the Ombudsman and the MP, and that the complainant is peripheral.

8. The title of this enquiry 'Parliament's Ombudsman Service' leads me to the conclusion that there is unlikely to be any substantive change. Perhaps most existing MPs like the constituency 'filter' as helping preserve the first-past-the post voting system.

The PHSO makes simple things complicated

9. When the time came to submit my complaint to Mr Jenkin MP, I asked the PHSO by e-mail for an exact address – maybe his committee staff dealt with it, or a particular assistant. In my earlier submission I described the PHSO's complicated answer to this simple request. My as yet un-submitted complaint even got a number and a deadline. It was the character of this response which made me want to look into what sort of body the Ombudsman had become. Incidentally, Mr Jenkin MP did none of the things the PHSO wrote he would do.

10. One month passed before I knew that my complaint had arrived with the Ombudsman (and therefore previously with Mr Jenkin). I suspect I did not get a routine acknowledgment from the Ombudsman, because of the way that my request for Mr Jenkins' address had already been recorded as a lodged complaint.

11. The first substantive response from the PHSO was a long all-purpose description of the bureaucratic procedures within the PHSO, a job description of a case-handler, and the setting out of five scenarios for resolving my complaint *without* a 'formal investigation'. On their website, the PHSO make play about how they can help people with disabilities or who do not speak English well. Even I, as a fully-alert graduate born in the UK in 1942, found the PHSO response challenging. Anyway, I was not in the least interested in the PHSO's internal procedures; I just wanted the PHSO to get on with my case.

The PHSO becomes less than transparent about when it takes up a case

12. In my naiveté, I had assumed that if I had gone through all the hoops and got as far as the PHSO, they would automatically take up my case. However, the PHSO become less than transparent about the circumstances in which they will actually do so. Thus, the PHSO went

on to say, in very fuzzy wording, that '*if we feel we need to look in more detail at your complaint we may decide to do a formal investigation*'. I had just wanted the PHSO to take up my case, but the PHSO had bamboozled me with expressions such as '*closer look*', '*more detail*' and '*formal investigation*'. Nowhere was it explained when and how a 'closer look' would give way to 'more detail' and then to a 'formal investigation'. And what exactly is a 'formal investigation'? It may be obvious to the PHSO bureaucracy, but it was never explained to me. Even the concluding Ombudsman's letter to Mr Jenkin MP did not say whether the outcome was the result of a 'closer look', a 'more detailed look', or a 'formal investigation'.

The PHSO seems not to appreciate that not all of their complainants work in offices

13. A further hurdle put in your way is the telephone call from the PHSO, apparently prescribed by their procedures. When it came one lunch time, I pointed out that my papers were upstairs, that it was nearly two months since I last saw them, but I accepted to continue. Let me also mention that, as I am retired, I have to buy my own computer, printer, scanner and stationery and to pay for my own postage and internet provider – unlike MPs and the PHSO. The PHSO seems to show little appreciation of this.

14. In my previous evidence, I had recounted the one-sided oral questioning from the PHSO, the employee ignoring my written reasoning that the Border Force was neither respecting UK immigration rules, nor EU legislation, nor the European Convention on Human Rights. I had gone through all the procedures, resulting in a cogent 10-page dossier sent to Mr Jenkin MP. In my view, the PHSO call was made at the behest of the UK Border Force, to get me to drop the case. I do not give the PHSO the benefit of the doubt.

Complaints against the level of service provided by the PHSO

15. I was so disturbed at the level of service, which went well beyond that described above (for example the PHSO described me as also complaining about the UK Border Agency, as if I needed to get a visa to enter the UK), that I wrote to a Deputy Ombudsman, as prescribed on the website. I would ask the PASC to distinguish between complaints against the level of service, and complaints against decisions. The former should not be 'in house' but should be put in the hands of some kind of independent assessor.

16. The way the PHSO's standard acknowledgment chits describe correspondents as '*'Complainant/aggrieved*" should be queried.

Complaints against the decision of the Ombudsman

17. I do not believe that there should be an appeal against a PHSO decision. However, I can understand that discontent with a decision can arise simply because the PHSO do not appear

to have acted diligently enough. An independent assessor of the level of service would help here.

18. The final response of the PHSO to Mr Jenkin MP made no mention of any further recourse, either on the substance (apart from a passing reference to the courts) or on the handling of the case. However, following receipt of my copy of the final letter from the Ombudsman to Mr Jenkin MP, I wrote to the latter with a copy of the European Commission's own view on the compatibility of the Border Force's answers with EU law. I added that I was not impressed with the workings of the PHSO. Mr Jenkin MP did not reply.

19. Keeping to the protocol, I copied this letter to the Ombudsman, thinking that the European Commission view would be of interest. I assumed I might get a reply from the PHSO thanking me for sending the Commission document, and noting my other comments. Instead, the PHSO only showed interest in procedures, writing that "*It is open to you to ask us to review our handling of your case under our internal complaints procedure…examining whether there were any flaws…etc. etc.*" My point here is that if a further review of the handling of the case is allowable within a certain period of time that should have been made clear in the 'final' response. Since I had achieved an apology from the UK Border Force, I did not see what more a procedural complaint could achieve *for me*.

20. One of my additional comments was to remark on the Ombudsman's response to the Francis report on Mid-Staffordshire NHS:

> *"Good complaint handling should be at the heart of the new NHS"*

To me, this quote said it all about what is wrong about the Ombudsman. Here was me thinking that good healthcare was at the heart of the NHS!

The Ombudsman should not be an Officer of Parliament

21. The PHSO comes across as a defensive and bureaucratic organisation. This may be down to its status as a creature of Parliament. Until now, Parliament seems to have been reluctant to hold the PHSO properly to account, in the way it does with other bodies.

22. A recent report of the PASC on the honours system criticised the awarding of honours to public officials (and business persons) just for doing his or her day job. The current Ombudsman was appointed a Dame Commander of the Order of the British Empire *'for services to equal opportunities'* - after heading the Equal Opportunities Commission for eight years. All other Ombudsmen with one exception have been 'Sirs'. The office of Ombudsman would surely be more convincing to the general public if the holder was not seen as already part of the Establishment.

23. Those who ‘do the work’ in the PHSO will not have such grand titles. However, I do find some of their job titles simply wrong. The PHSO has ‘Customer Services Officers’, as if I could take my custom to another Ombudsman. I also had communications from various ‘Business Support Officers’. Parliament did not set up the Ombudsman as a ‘business’. These examples rather illustrate how Parliament, through the PASC, has let the Ombudsman lose its way. It should become independent of Parliament, but reporting annually to Parliament.

May 2013

Written evidence submitted by Janet Treharne Oakley (COM 26)

1. The Ombudsman

I complained to the Ombudsman about my father's death in a Powys hospital.
It was mostly upheld and received quite a bit of press attention, Daily Mail, Daily Telegraph, Private Eye, TV channels etc.... it being a demonstration of how the NHS treats elderly patients.
http://www.dailymail.co.uk/news/article-1357796/NHS-neglect-left-father-calling-help-died.html

The key factor in this was that the case was scrutinised by an outside expert person, presumably a nurse, from the comments.

The case worker was also sympathetic. Therefore, although the case was not very well conducted(for instance the expert did not notice that my father had no food or fluid for 23 hours..I did) it achieved its objective in that the health authority concerned revamped the ward so that the dying had single rooms and therefore some sort of peace.

2. Arising from this case came another query and because it had not been covered, the Ombudsman gave me leave to raise it as a complaint. The second case worker had an entirely different attitude. From Day One I knew the outcome by his attitude. I tried to withdraw the case on that basis but was told that I couldn't. The unsurprising outcome was that the complaint was not upheld.

3. The PHSO

A. I had applied, under FoI for internal documents in my father's case. Some were denied. However the case worker decided to investigate them under DPA, as I was mentioned.

Told me I could read them..... then told me I could not.

Told me that I could take it to a judicial review. I asked how. I had no knowledge of what was in the document. What could I possibly tell a lawyer?

I asked if the document had been considered under public interest grounds ie the public should know what they are paying for, since the document appears to be a legal communication (the authority did not contact anyone else as far as I know).

My reasoning for this is that the public gave no idea that when they make a complaint to a 'nice person' in complaints, who they think will help them, the response that they get us drafted by a lawyer. Sometimes from an external firm and whose fees are paid by the taxpayer. What most people want is not to sue the organisation, just for things to be put right.

I did not get a reply to the public interest question.

B. My MP backed the public interest question and it was sent to the PHSO.

I received a reply stating that the decision was final - no explanation, or mention of the reasoning on the public interest question. The information officer at the PHSO drew attention to this and drafted a letter of my puzzlement, asking for an explanation from the PHSO. I received another abrupt letter with no explanation.

Rang up and asked to make a complaint as I thought it was badly handled.
In that people who are bereaved and bothered to construct an argument (and may have taken years to do so, as I did) should at least be given the basis for the decision. The arrogant person who answered me would not let me make a complaint. Her notes on our phone call were incorrect. My impression was that she had pre-judged the phone call and was not prepared to listen, therefore did not listen to and therefore did saw no compunction to note the facts. (Apparently she was incorrect and I have now made a complaint to the complaints officer.)

C. My MP also asked the PHSO if the legal advice in the Mid-Staffs case was disclosed.. Why wasn't my case comparable?

Answer: No new evidence. (Mid- staffs is around for years after my father's case.)
Once again, abrupt letter.. no explanation.

Conclusions

The Ombudsman

My opinion, having gone through this procedure, is that so much depends on the individual caseworker. I would advise anyone to give up if the initial interview does not seem to be unbiased. And for the Ombudsman to recruit staff of the a consistent and intelligent calibre - and to use external experts.

The disadvantage in using the Ombudsman to complainants is that the authority concerned sees the complainant's evidence - while the complainant does not see the authorities' response. This should be changed, to be fair to both parties.

The PHSO
My understanding is that the PHSO only support 1.5 percent of cases referred to them.

In other words, even though cases are backed by MP's, our elected representatives, the PHSO gives no explanations for its reasoning to the 98.5 percent of people who expect to see justice... Or at least a fair appraisal of their complaint.

As for the PHSO, as a publically financed body, I do not see the need for an organisation which basically -and seemingly arrogantly - rubber stamps decisions on this percentage without giving an explanation to the public. Especially in NHS cases.

It should be scrapped and a new body, which does not arrogantly dismiss public complaints with a civil servant ' Because I say so' attitude, overriding the fact that elected representatives have supported the cases.

May 2013

Written evidence submitted by Simon Cramp (COM 27)

1.A little about me if I may. My name is Simon Cramp and I am in my early forties and with no children and live with my brother. I am a disabled person who has dyslexia and dyspraxia and have in my pervious life served on the Ofcom older people and disabled advisory committee for seven years between 2004-2011.

2.So I hope to help you in your inquiry and look forward to see the report and your recommendations.

3.What objectives should Ministers adopt when considering how complaints about Government and about public services provided by Government are handled?

4.I agree that on the big issues we should have the public inquiry but like Parliament offers if you submit edvience a gratis copy of the final report instead of in the instance to read the final report of it was like 210 pounds. And I want to to get an answer why if I request a government document in hard copy my emails were ignored or it take months for someone to come back or I ring up to complain and there nothing avaible . p.s I don't expecting to with the committte remit to invergate I know it not what you do. But the point I making it seems there is no one in government ministers or official in certain government seem to think the eqauility act doesn't apply to them . And I have this problem since the current government came into power. And to complaint to ombudsman you have to go though your mp what if you have a fall out with them. You are stuff the act that set up the parliamentary ombudsman should be amedmend and I will come on to that question later in my submission

5. What gaps in the complaints systems exist; and how should ministers ensure they are addressed?

6.All of the above is a joke.

7. How effectively do Government departments and public service providers use complaints to improve the service provided?

8.They don't.

9. Who should be accountable for leadership and governance of complaints systems across government and its agencies?

10.The prime minister but the current one I have my misgiving about his judgement and weather it objective . I think the phone hacking scandal is a prime example employing a now ex special adviser when he resigned from a national newspaper and now is subject to criminal processing I bet stop there on that one I hope the committee get my drift. With my example.

11. How should data on complaints be gathered and monitored?

12.It not to me as if I can't complaint how can data be collected.

13.How should information about complaints be used to lead and drive improvement?

14.There is no system in my experience and yet even oon beneifit I am paying for civil servants to be in a job and wonder what I get back from the state in terms of service and and value for money

15.Absolute sweet nothing.

16.What do complaints cost; and how much money could be saved by learning from complaints?

17.Who knows? You can probably tell I think there is no system so instrocing something for people to be able tell the government what a rubbish service or misinformation they are given in the first point of contact . if there was a complaint system at Whitehall level it would be a start

18. How quickly do complaints systems deal with legitimate grievances and provide redress?

19.Waste of time— it doesn't happen in my experience.

20. How easy is it to make a complaint about a Government department or agency, and how could this be improved?

21.It doesn't exist in my experience.

22.Can people easily find their way around complaints systems?

23.No because often it time consumering and cost money and having to admit wrong doing and in the nhs paying money that is having to be divert from paitent care .

24. Do complaints systems provide proper access for vulnerable, disengaged, or excluded groups?

25.No it doesn't not winterboure care home runs by castback no in admistratior is a case of a good example and then when charges were laid they were pathric 2 years the most given to the people convicted— pathetic.

26. How welcome are complaints to government departments and agencies, compared to complaints to a department store or to a mobile phone company for example? What should government learn from the private sector? It needs to accept especially the examples I given to you in the instance re refusing or not answer request for hard copy of document in my view learn the law does not give government and I have to say some the reason they can ignore the

equaility act andit doesn't apply to them. There's scope in the mobile phone industry and customer law for shops and most other industry if the government is setting the law thourgh sceruity in parliament lead by example.

27.Do complaints systems succeed in making public services and government departments more accountable and responsive to service users?

28.No it a joke and discrimate agasinst people who have disabilities who carnt read things online and don't get enough from the state though the beneifts to be able to print off or can get to the library and pay the cost of printing things off or access to the internet as these are poular but with the cost of living going up something has to give.

29. Do complaints-handling systems achieve the right balance between nonjudicial and judicial investigations and remedies?

30.No it often goes in favour of say a bank or other comapines and with the reform on legal aid it will indirected discrimate against people who need there legal cost to be pay for to seek redress disappear because it no longer available.

31.How can ministers reduce litigation costs and defensive behaviour in favour of informal redress and openness?

32.Make civil servant are not offensive and in my case start give me a hard time because I remind of my right under the euaility act and it take them three months after I make the orginal simple request for document and they fail me.

33. How aware are service users of the various ombudsmen (such as the Local Government Ombudsman, Financial Ombudsman and the Housing Ombudsman)?

34.I am aware of it but it unfair that if you fall out with your mp or your mp doesn want to communicate with you as a consistent you can't access this service.

35. What lessons for complaints handling in the NHS are emerging from the Francis Report into failing at Mid Staffordshire Hospital?

36.Stop playing politics and and keep to your promised at employer level and politicial level anyone who fail and cause harm and possible Avoidable death should be charged and remove at least from there job with out a payoff and be struck off and made to do community work but not in the field they committed the offence but also if it warrant it life imprisonment should be a option and not just for high profile case that happen in court.

37.Finally I have been very critical of the question you pose because I have had such a rubbish deal and the stress this has caused has had an impact on my health. And it makes me quite angry. And think there should be a fair playing field but there is not. And that is why my submission is the way it is. May 2013

Written evidence submitted by Frank Edohen (COM 28)

<u>Background</u>

- My experience is NHS Trust Hospitals show a complete lack of interest, respect and dignity for the citizens of the UK. I will focus on Northwick Park, Harrow herein. I/we complain not because we are demonstrating mental pathology (as *** whispered to my bereaved Mother when I led enquiries), but are responding to cruel and unusual events that happen in these Trusts constantly. We do not do it because we are bored or have nothing better to do – we are very busy. It is a simple, natural reflex action of ordinary people unlucky to come into, indeed inescapable, contact with callous NHS Trusts. The reflex of the innocent citizen who goes about their daily business but then is greeted by the breathtaking and flagrant disregard for humanity being perpetrated in Trusts. There seems to be no where to highlight this plight; hopefully this forum may be a platform (the only platform it seems) to get aired the systematic victimisation being perpetrated by Trusts and the PHSO and formulate how TO STOP IT.

- My father died in an NHS Trust Hospital a few years ago. It was sudden and surprising. The Hospital said it could do nothing about it as he was very unwell and he could've died at any point elsewhere anyway. I claimed they missed key symptoms and the fact he was in hospital should have meant symptoms should have been picked up. The notes stated the symptoms were picked up but nothing was done about them.
  I contacted the PHSO to investigate why this was. The PHSO accepted regular and standard vital sign checks were performed i.e. after operation and thereafter on the hour. But ignored the facts:
  1. specialist monitoring was not performed at the right time.
  2. no post/pre-op specialist care for elderly as post-op death is common as stated in NCEPOD 2010 report. As a result he was isolated in an ex-private room bed with no access to a nurse bell.
  3. Nursing neglect and cruelty where he was extraordinarily and needlessly left on a bedpan for an hour despite crying out for help and subsequent sister cover up.
  4. Indifferent PALS service performance.
  5. As there was no appropriate monitoring there were continual attempts to discharge despite obvious dire condition of patient.
  6. On day of death having to follow a 'dead body trolley' around with porter as he did his pickups to get access to the morgue as he 'inconveniently' died on the weekend.

- This I stated did not address the fact more attention to detail was needed as the symptoms required immediate and specialist medical care. I constantly asked the PHSO to get an answer to why a particular Doctor's note that a heart event

was probably taking place was not acted upon. They consistently would not comment on this stating regular check-ups were sufficient, as the Trust pointed out. This was not the case as the patient died soon after. It seemed the PHSO quite simply did not want to challenge the Trust, regardless of facts. I gleaned more from the obstructive and passively-openly aggressive Trust's investigative nurse Pat Duckett than the PHSO. She speculated he died on the weekend as staff are not easily available and obvious symptoms are sometimes more sinister than staff perceive. Quite damming stuff I thought the PHSO will judge harshly. Not in any of their investigations were even these facts unearthed!

- The case coordinators were controlled by the consultants they use rather than act as detectives, understand and acknowledge my issue and get my questions answered. My perspective amounted to zero. I could only conclude there is corruption at the Trust **and** PHSO level. I question its reason for being as its verdicts can taint future judicial action. Moreover, suggest as a service user it should be disbanded and reformed as a fully defined law enforcement agency that quite simply uses detective/jurisprudence methodology and methods to unconceal corruption and subterfuge, in short investigate crime.

- Moreover, review of unresolved cases (in the service user's eyes unresolved) should be undertaken and legal proceeding should be enacted against all parties complicit in stopping the truth of corruption from being unearthed.

- Lest we forget the PHSO is a service to the public whose goal supposedly is to seek justice for it's users. The PHSO is totally inadequate to the objective of achieving justice for its users. The criterion of the successful outcome of cases i.e. Justice obtained yes/no, would substantially measure whether it is doing what it is set out to do. I am sure few achieve justice through the PHSO.

- Are the PHSO records available i.e. under the freedom of information act? They have not informed me that is the case thus I presume they are not. The PHSO has no accountability, no one can scrutinise what they are doing.

Herein I will address points set out on the Public Select Committee questionnaire.

1. There needs to be a regular review of unresolved complaints to ascertain whether the department is fit for purpose. The PHSO has a mirky remit as it's supposed to deliver justice. But the complainant is not asked if yes or no has the PHSO achieved justice at the end. They are supposed to be a credible alternative to court …what court just files away cases without a final outcome and the reason for it? Not fit for purpose of delivering justice I'm afraid. If necessary the PHSO should be ordered to achieve a satisfactory outcome or address gaps in their effectiveness and resume the case. The point is to achieve justice. What's the point of the organisation if it cannot accomplish this?

2. Similarly to 1. data should be analysed and where there is no satisfactory outcome it should be flagged. This should be performed by an overseeing agency to the PHSO on a weekly basis.

3. Procedure is very slow; and for no reason as they do not haul the trust in.

4. Complaints about a case's outcome go to the manager of the PHSO. It is my belief that the PHSO is complicit in the corruption of the NHS, especially in regard the death of patients. Therefore, the case overview is just a terse dismissal with no explanation as to why it has been dismissed. The manager states that procedure has been followed in dealing with a case and does not address the reason why the complainant does not agree. No comment at all is made about the rationale behind the incorrect decision. I claim a vital point has been consistently ignored, then the manager ignores this highlight of the highlight of the omission! Ultimately, it looks like the manager is there to call a halt to proceedings, no more than that. That is not treating the service user with due respect. There can be disagreement over outcome, but this is a case of simply violently shutting down the whole process without explanation. They echo what the sisters on wards do with complaints about nurses- simply deny it happened to shut you down. The PHSO notes for the case should be available to the service user. I presume as no one has told me they are not.

5. I believe the PHSO does not want to challenge NHS trusts. The trust will trot out routine platitudes like they do regular checks etc. so if they missed something that is tragic but not a fault. The PHSO does not know if regular checks are done beyond the Trust showing crooked records or if this alone is adequate in regards a desperately ill person. This applies to nurses, doctors and consultants. When it is clear there is a gap in care the PHSO's consultants will not contradict the NHS trust's specialists but trot out the same platitudes. Its as if they are reading from the same manual…albeit an ineffective and incompetent one that results in untimely death and misery. If court action ensued they would hinder a challenge to Trust practice as they backed the Trusts action. There is no consideration even with the evidence clearly presented to them that the Trust's experts are wrong and covering up.
Mid staffs bears this out horrifically, but its going on every day in micro fashion.

The answer may indeed not be judicial but one must remember the point of the PHSO is to achieve justice. To do this the PHSO must act like a Police force or court to establish who is lying in the Trust. They probably send out a questionnaire to the Trust! No, they need to investigate like a detective, interview under oath, re-interview etc. looking for contradiction and foul play. If like in our case, medical notes have been dumped then they should penalise the hospital for this severely and consider legal action. If a service user had an interview with staff and there are no notes to challenge what they said verbally as none was taken this should trigger huge suspicion etc. All of these 'omissions' act to hinder the quality of an investigation. But to just shrug one's shoulders saying, there's nothing that can be done as the notes are

not there is not how justice is achieved in the practice of unconcealing the truth, a truth which is almost certainly being deliberately concealed for sinister reasons.

6. No one is aware. The NHS literature says it's there when you complain to the trust but one does not know what it's remit is. Is it a full overseeing body that independently judges the NHS Trusts or an administrative escalation point with no power? We get a form that says: what do you want to achieve by using this service? We clearly want justice in every instance! This question suggests the PHSO does not know what its purpose is. Then when the service is used it is clear the PHSO is not geared up to authoritatively deliver justice. I call it a safety valve for the NHS Trust that gives the public false hope they can achieve justice.

7. The PHSO essentially ignores the service provider's need for justice. They take the complaint to the Trust. The Trust replies with platitudes. The PHSO does not effectively challenge them and tells you the case is closed. But as Staffs shows, the Trust is corrupt and it needs detective-style enquiry to uncover their lies. A suspicious, inquiring mind that knows what the gaps in information from the Trust means would help. They unearthed nothing! Be like a true detective, with detective powers rather than an extension of the inadequate corrupt practice of the Trust.
The PHSO staff and management should be sacked and a rethink about it's purpose should be performed. Make it a true detective agency. I mean, do the Trusts FEAR the PHSO? I doubt it.

9 The PHSO's service users should be monitored to see if it is achieving justice by an outside agency. Outcome of cases should be requested. i.e. Did the PHSO achieve justice for you? If not, then why not?

11. As regards the individual the PHSO should be a fully equipped justice agency akin to a court or law enforcement agency. They should interview staff under oath etc. Where documents are missing this should be construed as guilt..in short act like a Police agency would. Moreover, there needs to be an overseer to see if the PHSO accomplishes justice.

12. Totally ineffective! Simply does not do anything to intervene or challenge the ultimate of breach of duty of care – death! They do not address why a service user has a particular complaint about a Trust. If someone has died and the user is stating there was a clear gap in care the PHSO needs to understand why this perception is there. In the understanding it should be revealed what went wrong. In my experience they did not state why I have this perception. This is because the PHSO is corrupt itself recognising the reason for the perception would reveal there own corruption so they dismiss you with absolutely no explanation with an unresolved outcome. On there books it says the case has been investigated and no case to answer. The relatives know the right thing was not done and that's the point. One could go to court but they have hindered the case as they simply would not address the nub of the grievance thus making it look like a thorough investigation was conducted and nothing sinister was

found … when in truth they simply refused to address the real issue altogether. A case would entail taking the PHSO AND the Trust to court! This is total and utter victimisation of the public. PLEASE ACT NOW TO SAVE YOUR PEOPLE FROM FURTHER TORMENT.

May 2013

Written evidence submitted by Elaine Colville (COM 29)

1. As detailed by Ruth Grant and Robert Keohane in their seminal work: "Accountability and Abuses of Power in World Politics"[1] accountability requires a state of affairs in which some actors have the right to (a) hold others actors to a set of standards, (b) judge whether those actors have fulfilled their responsibilities in light of those standards, and (c) impose sanctions if they determine that those responsibilities have not been met.

2. The PASC and other parliamentary select committees are well aware from the records they hold that, over a period of time commencing in October 2007, I have reported to the UK Government, Parliament, regulators and other "competent authorities" certain serious matters the details of which are not necessary to rehearse for the purpose of this submission. It is sufficient only to state that no one wants to take "responsibility" for investigating the complaints in question.

3. What is relevant is the conclusion to be drawn based on the factual scenario. Namely, that there is no integrity in public life. The system of complaints handling in this country is not fit for purpose. It is all "capture". A "club" of vested interests that no one is minded to break up – extending to Parliament itself. The result is a culture of systemic cover-up. The mantras of "governance", "regulation", "accountability" and "responsibility" are all false pretences.

4. Unless and until complaints processes have teeth through proper sanctioning and become, and are seen to be, truly independent and objective there can be no confidence in those processes. All that will persist are current systemic abuses.

5. It devolves on Parliament to sort out this egregious state of affairs.

May 2013

1
https://portal.publicpolicy.utoronto.ea/en/courses/UniversityofOttawa/AP15116DemocraticGovernanceandPublicManagement/Courseware%20Library/September%2028%20%20Conceptions%20and%20Practices%20of%20Accountability/Grant%20and%20Keohane.pdf and
http://www.iilj.org/courses/documents/hc2004.keohane.grant.pdf

Written evidence submitted by J Pocock (COM 30)

In reply to your Question Paper 1 to 10:

1. Objective, without political bias – if possible.

a) Gaps – correlation through all the complaint stages – imperative as often lost. Many people have told me they have seen this happen when complaint systems comprise of stages or change of caseworker.

2.`I have not seen evidence of complaints being used toward anything more than a monitor system, more often than not the complaint is mitigated or "played down".

2a (no suggestions)

b) Data-Voice Dialog Recording of all telephone conversations with complainants needs to be implemented. I have seen in the absence of Verbal Dialog Recording mere "notes" have been falsely constructed with prejudice.

My recent experience:

The "notes" of my dialog with staff were stored on computer, I had seen this act unfold in my complaint to the PHSO Review Team all active in this way along with the Manager, she had filled over an A4 page from a short telephone conversation with me duration 2 mins 47 seconds – I requested her "notes" since my F.O.I request recently.

c) Lead & Drive improvement from complaints only when honesty and candor exist together

d) (not known)

3. Reasonably quickly at times, often hard to evaluate as the complainant.

4. Hard work – the complexity of complaint stages – also, the remit is often unclear at the outset.

4a) I doubt if the majority of people could find their way through the many complaint 'stages'.

b) not known.

c) My simple personal inquiries show Government Departments are more 'shy' of complaints.

d) not known.

5. My complaints I recall from reference were often addressed to prevent any continuity.

a) - as above – Honesty & Candor

b) as above – also, respect their position and responsibilities away from their complacency.

6. Not known.

a) not known.

7 To not be “asleep at the wheel” – also time for the regulatory bodies to become effective.

a) not sure.

8. not known.

9a) b) Though the Public, I could imagine a good “listening ear” such as Margaret Hodge.

c) A single point good, yet it maybe too big to manage.

10. I think we have to deal with “weeding out” our own problems before looking elsewhere.

Thank you.

May 2013

Written evidence submitted by Robert Devereux, Permanent Secretary, Department for Work and Pensions (COM 31)

Public Administration Select Committee- Complaints: do they make a difference?

In advance of my appearance on 11th June, I thought it might be helpful to provide the Committee with some background information about the work of the Cross Government Complaints Forum.

Background:

The Ombudsman's 2010/11 review of complaint handling by government departments and public bodies was published on 25th October 2011. The Ombudsman concluded that complaint handling across government was inconsistent, haphazard and unaccountable - operating without any overarching design, standards or common performance framework.

The Ombudsman said:

- I am not advocating a "one-fits all" system for handling complaints about government departments and other public bodies. Such an approach would preclude flexible processes, designed to be relevant and accessible to the needs of their different customers;
- I do not have the mandate or the mechanisms to provide assurance on complaint handling efficiency and effectiveness across government. Neither does anyone else;
- There needs to be a shared understanding between the public, government and the Ombudsman about what constitutes good complaint handling. The Ombudsman's Principles of Good Complaint Handling are a good starting point for government in the task of ensuring that all departments share an understanding of the importance of fairness, transparency and accountability. But they will not evolve further without strong leadership from the top.

The Ombudsman called for government departments and public bodies to:

- develop clear standards for complaint handling that users and commissioners can reference in holding public service providers to account;
- make better use of learning from complaints to drive improvements in public services; and
- develop comprehensive cross-departmental information about the volumes, nature and outcomes of complaints and associated costs.

The Forum

My department took responsibility (from NHS Direct) for managing, chairing and administering the Cross Government Complaints Forum in May 2012. The Forum is chaired by Christopher Evans, DWP Deputy Director with responsibility for Complaints. Mr Evans keeps me updated on the work of the Forum, and I have asked him to alert me to any issues which might benefit from my intervention including with other Permanent Secretaries.

Under our management, the Forum has agreed the following terms of reference :

- Forum *"members'* will be drawn from organisations which are subject to investigation by the Parliamentary and Health Service Ombudsman (the Ombudsman's Office is also represented at each meeting of the Forum);
- the Forum will identify and share best practice in complaint handling, and associated policies and procedures;
- the Forum will develop and maintain high level standards for complaint resolution within public services, which can be used to inform the policies and procedures of individual departments / agencies (having regard to the Government standard - Customer Service Excellence and The Ombudsman's Principles of Good Complaint Handling);
- the Forum will develop and maintain cross government best practice guidance.

Membership of the Forum has increased significantly in the last year. It currently includes representation from a wide range of departments/bodies **(Annex A provides details of Forum's current membership).** The Forum meets formally three times a year.

Since my department took responsibility for managing the Forum in May 2012, the members have:

- developed cross government complaint resolution standards in response to the Ombudsman review **(see Annex B)** and a supporting framework (a tool kit to help assess compliance against the standards);
- worked with Civil Service Learning and the Ombudsman's Office to develop "Good Complaint Handling" e-learning for operational delivery staff; and
- agreed to work with Civil Service Learning to:
  - develop guidance / learning on how to deal with vexatious / persistent complainants (Cabinet Office and Ordnance Survey are leading on this);
  - develop guidance / learning on dealing with complaints from vulnerable customers or customers with disabilities (Civil Service Learning are leading on this); and
  - reach consensus on the definition of a complaint (the Department for Transport are leading on this).

The Cross Government Standards and Framework are intended to help government departments *I* bodies demonstrate that they are bringing the Ombudsman's Principles of Good Complaint Handling to life within their complaint resolution processes and procedures. They can be used to:

- inform the development of individual government departments / bodies complaint resolution processes and procedures;
- provide a framework against which government departments / bodies can assess compliance with the standards;
- direct improvement activity aimed at achieving compliance; and
- provide the basis for structured comparison/discussion on how the standards are brought to life within individual departments / bodies - to inform learning / continuous improvement.

The standards were finalised in late 2012, and Members were asked to seek agreement, though their internal decision making processes, to sign up to, or agree to work towards, compliance with the standards. To date 30 Departments have signed up to use the new standards, the majority of those who are yet to pledge their commitment are currently considering the standards and how they would apply to their organisation.

Annex A.
Members 1 of the Cross Government Complaints Forum:

Main Department	Agency/ Body/ NDPB
Department for Work and Pensions	• Jobcentre Plus • Pensions, Disability and Carers Service • Child Support Agency • Independent Case Examiner • Health and Safety Executive
Department for Transport	• Office for Rail Regulation • Driver and Vehicle Licensing Agency • Driving Standards Agency • Vehicle and Operating Services Agency • Highways Agency • Maritime and Coastguard Agency • Government Car and Despatch Agency
Her Majesty's Revenue and Customs	• Valuation Office Agency • The Adjudicators Office
Home Office	• Her Majesty's Passport Office • Disclosure and Barring Service • United Kingdom Border Agency
Cabinet Office	• Gov.UK (part of Government Digital Service)
Department for Business, Innovation and Skills	• The Insolvency Service • Her Majesty's Land Registry • Ordnance Survey • Companies House • Technology Strategy Board • ACAS • Independent Complaint Reviewers Office
Department for Education	• OFQUAL • OFSTED
Department for Environment, Food and Rural Affairs	• The Food and Environment Research Agency • Rural Payments Agency • Environment Agency • Natural England • Marine Management Organisation
Department for Energy and Climate Change	• The Coal Authority
Department of Health	• The Food Standards Agency

	• Medicines and Healthcare Products Regulatory Agency • Public Health England • Care Quality Commission • Monitor • Health and Care Professions Council • National Institute for Health and Clinical Excellence (NICE) • NHS Blood and Transport • NHS Litigation Authority • NHS Direct
Ministry of Justice	• Her Majesty's Courts and Tribunals Service • Office of the Public Guardian • The National Archives • Office for Judicial Complaints • Criminal Injuries Compensation Authority • Information Commissioner's Office • Legal Aid Agency • Youth Justice Board
Attorney Generals Office	• Serious Fraud Office
Department for Culture, Media and Sport	• Equality and Human Rights Commission • OFCOM
Ministry of Defence	• Service Personal and Veterans Agency • Military Corrective Training Agency
Professional Standards Authority for Health and Social Care	
Department for International Development	
Charity Commission	
National Audit Office	

1 Member is defined as an organisation whose complaints are subject to investigation by the Parliamentary and Health Service Ombudsman

Annex B:

High Level Complaint Resolution Standards:[2]

(1) Our complaint process is accessible and easy to use

(2) We provide staff with clear definitions and guidance about our complaints process

(3) We focus on resolving complaints within specified timescales and (where possible) to the complainant's satisfaction

(4) We have mechanisms in place for assuring the quality of our complaint resolution procesess

(5) We have clearly defined our complaint information requirements

(6) We use lessons learned from complaints to improve our service

2 Summary definition of "standards": basis for comparison - intended to be aspirational. A summary of good and best practice rather than general practice, designed for voluntary use.

Written evidence submitted by Karen Hudes (COM 32)

Complaints: do they make a difference? ·
permitting corruption to remain unaddressed is not an option

1. When government departments and public organisations are not held to account, irreversible harm may occur that cannot be put right. The high cost of permitting financial weakness to be concealed by poor accounting and auditing practices has been amply demonstrated. My complaints to the World Bank's oversight agencies, including the UK's Executive Director, Governor, Ambassador in Washington, Serious Fraud Office (SFO), the International Organization of Supreme Audit Institutions, the International Organization of Securities Commissions, the United States National Advisory Council for International Monetary and Financial Policies, Fitch Ratings, Moodys, and Standard and Poors have fallen upon deaf ears. Failure to correct the internal control lapses and corruption that I have reported is about to result in a state of permanent backwardation in the gold markets, interrupt the financing of world trade except through barter, and plunge the world into a depression from which recovery is unlikely.

2. As a World Bank bondholder, on September 28, 2010, I informed the SFO of material omissions in the accuracy of the World Bank's financial reporting due to the World Bank's internal control lapses and KPMG's failure to follow Generally Accepted Auditing Standards. I provided the SFO a chronology of such lapses, which included a Letter from Jean-Louis Rioda, Acting Head of the European Community's Anti-Fraud Office: "I hereby acknowledge receipt of your correspondence received on 18/05/2010 in which you provide OLAF with information regarding 'the impaired ethics and legal functions in the World Bank'".

3. The World Bank's Audit Committee requested an audit of the World Bank's internal controls over financial reporting. The auditor may form an opinion on the effectiveness of internal control over financial reporting only when there have been no restrictions on the scope of the auditor's work. KPMG itself imposed such restrictions on its own audit team. A scope limitation requires the auditor to disclaim an opinion or withdraw from the engagement. KPMG's unqualified opinion prevented bondholders from requiring mitigating measures to correct corporate governance irregularities and improve the quality of the World Bank's financial reporting.

4. The SFO called the United States Security and Exchange Commission (SEC) on 10 October 2010, but the SEC only stonewalled. On 29th March, 2012 the Economic Affairs Committee of the UK House of Lords recommended that funding to the World Bank should be reduced "while a more detailed re-evaluation is carried out."
http://www.publications.parliament.uk/pa/ld201012/ldselect/ldeconaf/278/27802.htm

5. On 24th July, 2012 I followed up with the FSA, under reference number PC159743/ISS10622211. I have repeatedly reminded the FSA and the UK Parliament that the World Bank receives funding from UK taxpayers and bondholders and is subject to oversight by Parliament and the FSA. Instead, both Parliament and the FSA have abdicated their responsibility to ensure that the World Bank's financial information to bondholders is correct.

6. The House of Commons International Development Committee and the House of Commons Public Administration Committee published my testimony that the World Bank was already in contempt of an 8th April, 2005 letter [1] from the Joint Economic Committee of the US Congress to the World Bank inquiring whether "the Bank's Board of Executive Directors always is in possession of accurate and timely data on the Bank's accounting and financial position."

> Written Evidence for the inquiry into The work of the Independent Commission for Aid Impact, published July 7, 2012 available here:
>
> http://www.publications.parliament.uk/pa/cm201213/cmselect/cmintdev/writev/402/contents.htm
>
> Written Evidence for the inquiry into Public engagement in policy making, published November 2, 2012 available here:
>
> http://www.publications.parliament.uk/pa/cm201213/cmselect/cmpubadm/writev/publicpolicy/m03.htm

7. In June, 2012 I recommended a simple admonishment: "The UK Parliament's Select International Development Committee [and the European Parliament's Committee on Budgetary Control] share[s] the Joint Economic Committee's goal "that the Board of Directors and the public are being presented with accurate and timely financial information and that any accounting irregularities are promptly discovered, disclosed and corrected....Under the World Bank's COSO framework, it is also necessary to determine whether the World Bank's internal control system has the necessary critical underpinnings."

8. Today's dire circumstances call for immediate and forceful intervention in the hope that time still remains.

June 2013

[1] (Poor) online copy : http://kahudes.net/wp-content/uploads/2012/05/exhibit2.pdf

Written evidence submitted by Margaret and Janet Brooks (COM 33)

How effectively do public service providers use complaints to improve the service provided?

How quickly do complaints systems deal with legitimate grievances and provide redress?

How easy is it to make a complaint about a Government department or agency, and how could this be improved?

Can people easily find their way around complaints systems?

What gaps in the complaints systems exist?

Complaints: do they make a difference?

We made a serious complaint to an NHS Trust in 2010 regarding the avoidable death of our mother while she was in its care. We learned over the year and 4 months of the Local Resolution process that:

The NHS complaints system was not effective. It:

- did not deal with our legitimate grievances
- did not attempt to bring the facts to light or to investigate them.
- did not provide redress

The NHS Trust's approach to complainants was defensive. It:

- withheld relevant medical records.
- did not take statements from staff who were present when the patient came to harm
- allowed senior staff who were not independent but who were themselves the subject of criticism to be the judge of their own actions.
- Allowed the Trust's Legal Lead to effectively control the Local Resolution meeting when the relatives were not allowed to be legally represented.

In our experience, the complaint system was so obstructive and took so long that only the most tenacious complainant would get to the end of it.

In our view, it is not a case of whether there are any gaps or weaknesses in the NHS complaints process that need to be addressed.

The NHS complaints process needs to be radically overhauled.

We realise the Parliamentary Select Committee does not investigate individual complaints.

We speak from our own experience and are submitting this information as an illustration of how serious NHS complaints are sometimes dealt with.

The complaint

1. In 2009, our mother was admitted to her local hospital for planned, elective keyhole surgery.

2. She had been told by the Consultant Surgeon and Anaesthetist that, because of her age, she was a high risk patient.

3. Therefore, for her safety following surgery, post-operative care in a High Dependency Unit (HDU) bed was a pre-requisite. It was on this basis, she gave her consent.

4. However, following surgery, without her knowledge or consent, she was consigned to to a 0-level temporary contingency ward, which had only been open for 5 days.

5. Here, when she experienced a known complication of her surgery which needed prompt action, the nurses refused to help her, saying they were too short-staffed.

6. My sister and I were left to cope with the medical emergency for 7 hours unaided by staff, in which time our mother came to serious harm.

7. She died in ITU 3 weeks later.

The Complaints Process

8. We wrote our first complaint letter to the Trust 5 days after the death of our mother.

9. We wanted to know how the incomprehensible decision was made to send her directly from major surgery to an understaffed, poorly equipped contingency ward where she almost immediately came to harm.

10. We wanted to know how the nurses on the ward could have had so little understanding of their role as to leave a patient without nursing attention for over 7 hours in a medical emergency.

11. We thought the complaints process would establish the facts.

12. However, the Trust's 'investigation reports' gave us very little information.

13. The reports were confused. Words were left out of sentences. Sentences about different subjects were run together and put out of logical order.

14. In answer to our question about the nurses, it was said the nurses had been 'reminded of their responsibilities'.

15. We had requested the medical records in February but it took almost 6 months for the Trust to supply a set of records that was anywhere near complete.

16. When we got them, we found that records were missing from every point where our mother came to harm.

17. Nevertheless, we still learnt some new and extremely upsetting facts from the medical records regarding failures in our mother's treatment and care.

18. When we tried to ask the Trust about these, we were told 'new' issues could not be raised at this stage - even though the issues were only 'new' because of the Trust's delay in giving us the medical records.

19. In August 2010, eight months after we started the complaints process, we requested a Local Resolution meeting since it was clear that the Trust was not going to give us any answers.

20. It took another four months to get a date for the meeting.

21. As the provisional date approached, we renewed our attempts to get the Trust to disclose missing chest x-ray reports, ITU nursing notes and microbiology so that we would go into the meeting prepared.

22. We only had half a day's notice of the confirmed date of the Local Resolution meeting in December 2010.

23. This meant that our ICAS representative let us down, and the friend who had agreed to act as our witness was snowed in at a foreign airport.

24. We had asked if we could make an audio recording of the meeting. We were told this would not be allowed. Instead, the Trust would supply us with minutes.

25. We were introduced to Mr Y, and we were told he would be taking the minutes.

26. We later found out that he was the Trust's Clinical Governance Support Manager, a trained barrister and the Trust's Legal Lead.

27. As an adviser to the Trust, he was not bound by the same code of 'openness and honesty' as NHS managers. His duty was to his employer not to the patient or her relatives.

28. We found the meeting surreal and bewildering. It was as though everything that was said was tightly controlled and pre-arranged to a plan which did not actually involve us.

29. The Consultants spent the first ten minutes talking to each other about the allocation of HDU beds without addressing our question as to whether there had been an HDU bed available when our mother went to surgery.

30. Neither did they explain why, if the only bed available for our mother's post-operative care was on a temporary contingency ward, her elective surgery had not been cancelled.

31. Things that we knew to be untrue were said at the meeting. Statements that had been made previously by the Trust in the investigation reports were denied.

32. Facts from the medical records were contradicted.

33. When we asked how it was that the nurses refused to help our mother over a 7 hour medical emergency, the Consultants said it was unfair to blame the nurses as our mother should never have gone to that ward.

34. Yet, they also told us that once the temporary contingency ward had been opened by the Divisional Nurse Director due to bed shortages, our mother's transfer to it would have been 'automatic'.

35. We asked how the Divisional Nurse Director could have over-ridden the clinical judgment of the Anaesthetist and the Consultant in this way.

36. The Consultants agreed that it had not been appropriate for our mother to go to this ward, where there were no electric beds and where, according to the Consultant responsible for her care, 'nurse staff levels were not adequate to say the least'.

37. But they did not explain how such a thing could happen. And without explaining this, there was no guarantee it would not happen again.

38. We spent the week writing up our notes from the Meeting into a set of minutes which represented what had been said.

39. However, when we received the official Trust minutes from Mr Y, we found that he had misquoted us, said we'd agreed to things we hadn't agreed to, misrepresented the medical records, misquoted the doctors present, and omitted the most important points of the discussions

40. Our letter disputing point by point of the Trust's minutes took us three weeks and resulted in a 27 page document which the Trust ignored.

41. Although it was agreed both sets of minutes would be 'kept under the same cover' the minutes that were subsequently used as the official record were always those drawn up by the Trust's Legal Lead.

42. The Local Resolution meeting had supposedly ended the Local Resolution process.

43. We tried to apply to the Parliamentary Health Service Ombudsman but were told they could not accept the case until the Trust declared it had explored all reasonable avenues of resolution.

44. By now, we were drained and exhausted and desperate to have nothing further to do with the Trust.

45. The Trust treated us as opponents to be thwarted, not bereaved relatives, and their strategy of appearing to fulfil the requirements of the Complaints process without releasing any information had the effect of tormenting us and prolonging our grief.

46. Mr Y dragged Local Resolution out for another 4 months until we were out of time for the Ombudsman. Nevertheless, the Ombudsman, accepted our complaint.

47. We told the Ombudsman's office about the records that we had never been able to obtain.

48. We were told the Ombudsman had the powers of a high court judge and could enforce disclosure if records were withheld.

49. We were told it would take the Ombudsman a year to investigate our complaint.

Nursing and Midwifery Council

50. At the beginning of 2011, we had made a Fitness to Practice referral to the NMC regarding the nurses who had refused to help our mother on the night she came to serious harm.

51. Nine months later, the NMC told us that they could not proceed with this referral, as the NHS Trust had informed the NMC that they had not been able to identify the nurses who had been on that shift.

52. We were shocked by this. This meant the Trust had never carried out an internal investigation into how my mother came to serious harm.

53. We pointed out to the NMC that it could not be true that the Trust could not identify the nurses.

54. Records have to be kept of the nurses working on the Trust's wards. The Trust had paid these nurses a salary. We had supplied the date and time of the shift and the nurses' signatures.

55. However, the NMC closed the case, sending a letter to the CQC to 'flag up' the issues of our specific case, and to raise wider concerns about the 'lack of permanent staffing, training or leadership and minimal resources' on these temporary contingency wards.

56. The letter stated that the NMC was particularly concerned that the Trust felt 'no need to investigate or plan to prevent the examples of poor care on its contingency wards in the future'.

The Care Quality Commission

57. We hoped the CQC would follow up the issue of the contingency wards. However, the CQC was unable to look into individual cases.

58. A full CQC Investigation into the NHS Trust in whose care our mother died was in progress at the time.

59. When the CQC published its report, this highlighted the pressure surges in the Trust's emergency departments and the need for effective management of bed capacity.

60. We wrote to the CQC, pointing out that the Trust's Pressure Plan showed that when there was sustained pressure on the emergency departments, the Trust created capacity by opening contingency wards at short notice.

61. We asked the CQC whether they would be recommending any action to safeguard patients placed in these temporary contingency or escalation wards.

62. They were not able to give any reassurance on this.

The Parliamentary Health Ombudsman

63. After a year, the Ombudsman published her report which fully upheld our complaint.

64. The Ombudsman found service failure in that she identified 'serious concerns about care and treatment' from both nurses and doctors and found maladministration in the way the Trust handled our complaint.

65. The Ombudsman agreed with the Trust that our mother should not have gone to the temporary contingency ward.

66. But she did not investigate what system was in place that had caused this to happen.

67. Nor had she investigated any of the events where our mother had come to harm.

68. When we asked the Ombudsman to supply the records upon which she had relied, it became clear that the Trust had withheld over 100 records from the set that had been supplied to the Ombudsman.

69. Records were missing at every point where our mother came to harm.

70. As a result, the Ombudsman had not been able to investigate these events.

71. Three years after our mother's death and despite the 'official investigations' carried out by the Trust and the Ombudsman, we still do not have any answers as to why what happened happened.

72. Since the Ombudsman had not been able to effectively investigate the case, the recommendations she asked the Trust to implement were irrelevant to the events that actually occurred.

73. That being so, there is nothing to stop such events happening again.

74. In our view, as we have stated, it is not a case of whether there are any gaps or weaknesses in the NHS complaints process that need to be addressed.

75. The NHS complaints process needs to be radically overhauled.

76. The current situation is that it is open to an NHS Trust to manipulate and abuse the system to prevent facts coming to light, without any risk of recourse or repercussion.

77. It seems to us that NHS Trusts when faced with complaints that they have caused serious avoidable harm / avoidable death to a patient should be required to disclose a copy of the patient's medical records immediately to an independent body, from where these could be accessed by investigators and / or relatives if necessary.

78. We cannot see what possible reason there can be for an NHS Trust to withhold the medical records from the relatives for 6 months, other than the hope that the grieving relatives will find the process too lengthy and too traumatic to pursue.

79. There should be independent oversight of the Trust's investigation to ensure that it is effective, timely, transparent, that statements are taken and that facts are brought to light.

80. Witness statements should be disclosed equally to both parties.

81. There is no reason we can see why an effective internal investigation could not be conducted and completed within 2 months of the events complained about.

82. In our case, 'Local Resolution' took 16 months. It consisted of 3 so-called Investigation reports which uncovered no facts at all.

83. Almost everything we knew about our mother coming to harm, we knew because we had been present on the ward with our mother when it happened.

84. Everything we subsequently learned about the harm our mother came to, we learned from what medical records the NHS Trust was prepared to disclose to us.

85. The Trust's protraction of the complaints process while failing to answer our legitimate questions causes us anguish.

86. The fact that we are, more than 3 years later, still having to ask the same questions we asked 5 days after our mother's avoidable death, prevents us from coming to terms with it, and means that we are condemned to relive the same traumatic events repeatedly without ever achieving any resolution.

87. In our experience, the complaints system did not succeed in making NHS public services more accountable and responsive to service users.

88. It seemed to us a well-honed, efficient machine for preventing any facts about avoidable deaths caused by an NHS Trust from ever coming to light.

June 2013

Written evidence submitted by Jan Middleton (COM 34)

Summary:

A - NHS Trusts and healthcare providers have not made an effort to implement the Francis Report recommendations

B - The same tendency to evade responsibility and accountability continues

C - There is no mechanism for running one investigation into lack of co-ordinated care provided by several agencies unless all agree to this course

D - There is no will to investigate complaints about general standards as opposed to a consensual complaint from an individual patient

1. Background: This submission is from Jan Middleton, acting in both a personal capacity and as Lead Member of the London branch of Cure the NHS.
2. I would like to appear before the Committee to give evidence, as on my observations too often those appearing are actually in receipt of funding from central government or NHS Trusts or commercial providers of services to the public sector, even when claiming to be commenting in an independent capacity and/or despite being set up as a charity.
3. My background is that I was a lawyer until negligent medical treatment by two lead clinicians *** at Charing Cross Hospital and Chelsea & Westminster Hospital throughout 2009 and 2010 which amongst other things left me with brain damage and permanently unable to work. ICHT admitted liability in 2013 and paid substantial damages, as well as sending me an unmitigated apology for the poor level of care that I had received. As a result of these utterly horrendous, life destroying experiences I became involved with patient campaign groups including Cure the NHS.
4. I also gave written evidence to the Parliamentary Select Inquiry into NHS Complaints and Litigation, which can be found here: http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/786/786vw10.htm
5. After the 2013 publication of the report by Robert Francis QC into the Mid Staffs scandal and the continuing failures in health care provision, one might have hoped that there would have been some evidence of a change in attitudes by NHS Trusts particularly in the deliberately evasive approach to complaints. Regrettably, people are finding that isn't so as my most recent experience set out below demonstrates.
6. Factual/Experience1 Francis recommended that every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.
7. The NHS Ombudsman Dame Julie Mellor expressed concern in April 2013 (http://www.guardian.co.uk/society/2013/apr/26/nhs-ombudsman-patient-complaints-mid-staffs) that NHS Trust Boards were still ignoring concerns raised.

Jeremy Hunt backed this, saying that Boards must act on complaints and use them to improve patient safety.

8. In October 2013, I was called by the Sister of the A&E at Nuneaton George Eliot Hospital regarding her severe concerns about the mental state of an elderly a relative for whom I was named as next of kin and with whom an Enduring Power of Attorney (EPA) had been set up some years earlier after an attempt by another relative to have her sectioned so that the latter could take financial advantage. At that earlier time, I had seen that my elderly relative received independent legal advice and that EPA arrangements were set in place to prevent this happening again.
9. The concerns of the A&E sister about my elderly relative's mental state and particularly her bizarre behaviour with regard to money – for example she had arrived at A&E with a dirty carrier bag containing £1,000 in cash which she refused to check in for safe keeping – were reflected by the managers of the sheltered accommodation in which she was living - where for example she refused to pay rent until she was over a thousand pounds in debt whereupon she would insist on paying in cash that she had withdrawn herself from the bank and carried home in a carrier bag. They also expressed severe concerns that she was increasingly incapable of looking after herself and required a greater care package than her current sheltered accommodation could deliver. Other independent third parties expressed a concern that she was being taken financial advantage of by "friends".
10. Whilst an in-patient, she was assessed by a consultant psychiatrist whose view was that she was incapable of handling her financial matters. My elderly relative asked me to sort out her financial matters for her as her Power of Attorney. I appointed a specialist solicitor FJ to assist with this, as my relative's matters were very tangled going back thirteen years. In addition to commencing sorting out this mess, we applied to have the existing EPA registered. My elderly relative was informed of all of this and the solicitor FJ's view was that she had good understanding of what we were doing and that it was with her consent.
11. In line with proper procedures, all other significant relatives were informed. The only objection was from the relative who had tried to have my elderly relative sectioned behind everyone's back some years earlier, and told her that they would transfer my elderly relative's house into their own name but allow my elderly relative to continue living there if she paid rent to them.
12. Medical staff considered that my elderly relative's physical state did not require prolonged hospitalisation but that because of her mental health problems they would not discharge her until adequate arrangements had been made.
13. However, my elderly relative left the hospital without FJ's or my prior knowledge and we were subsequently informed that she had gone to an address to be looked after by friends, and would be visited by the allocated mental health nurse who would check out its suitability. It transpired much later that this address did not exist and in fact she had returned alone to her empty former family house where there was no furniture, no adjustments for her numerous disabilities and no care package.
14. An "independent mental health advocate" *** had been appointed from Independent Advocacy which purports to "provide a voice to people who need support to make choices" and my elderly relative was also allocated outpatient nursing services from

Coventry & Warwickshire Partnership Trust (C&WPT) which provides mental health and learning disabilities for the area. Both of these organisations were aware that I live in London and am ill with cancer, and that I wanted to ensure that my relative was in a protected position as quickly as possible given my own health prognosis and the fact that concern had been expressed by independent third parties about her ability to care for herself, and she had been assessed by a consultant psychiatrist as incapable of dealing with her financial matters.

15. Notwithstanding all of this, when my relative was later re-hospitalised, neither the solicitor FJ – who had been in regular direct contact with *** and the C&WPT staff allocated to my relative's case - nor I were informed about this and found out only by chance some time later. When we enquired of both C&WPT and Independent Advocacy how this had happened, we received a brusque response that neither organisation was under any duty to inform us, and "on advice" they would have no further contact with us. They refused to explain what advice or from whom.
16. Some time afterwards, we received information from the Office of the Public Guardian that my elderly relative had objected to the EPA being registered. It transpired that notwithstanding the consultant psychiatrist's assessment, *** had persuaded my elderly relative to object to the EPA being registered, on the basis that *** believed that it was unnecessary. *** had written the letter of objection and obtained my elderly relative's signature. *** had not informed FJ or me about this and we therefore continued our work on my elderly relative's matters for several weeks after this objection had been sent, until the OPG got in touch to inform FJ.
17. Because of this objection, I had to withdraw and FJ had to cease the work that she had been doing very successfully and close her firm's file. A solicitor in Warwick, DA, of Moore Tibbets Solicitors, had contacted FJ to say that she had been appointed as my elderly relative's representative via a referral from ***.
18. Some months later, when no request for the transfer of the file had been received from DA, I contacted DA to ask why not. In the interim I had been copying to her relevant correspondence and had also expressed my concerns about the behaviour of ***. Only then – some months after her first contact with FJ – did DA inform me that she had not been appointed after all. She gave no explanation as to why she had not contacted FJ or me to inform us of this or why she had continued to receive correspondence relating to my elderly relative's matters when she had no legitimate reason. She did however attempt to warn me on behalf of *** that the concerns I had raised were "potentially defamatory" – as a former lawyer, I knew this to be utter nonsense and suggested to DA that if she had grounds for making such an allegation she should let me know what they were. She was unable to produce any. This trick of alleging "defamation" when well- founded concerns are raised about healthcare staff is well-known by patient campaigners.
19. The considerable funds that FJ had recovered to date had to be transferred to my elderly relative's bank account as the file was to be closed – so it thus became available to the exploitative friends. No psychiatric second opinion had been obtained that contradicted the assessment of the first consultant psychiatrist that my elderly relative did not have the capability to manage her financial affairs

20. I made a formal complaint to Warwickshire County Council (Social Services), Independent Advocacy and C&WPT asking for a joint investigation into the joint failures of the three to co-ordinate their services and adequately safeguard vulnerable persons' interests. Initially all three refused stating that my elderly relative's consent was required. I pointed out that my elderly relative's consent was not required because I was not asking for an investigation into her specific treatment but into their general procedures, the lack of co-ordinated response to the needs of vulnerable persons and how why advocates were permitted to overrule the medical assessment of a consultant psychiatrist and the views of numerous independent other third parties and then leave their client without legal representation and with no-one protecting their welfare, living alone in unsuitable accommodation and being financially exploited.
21. I also suggested to Warwickshire Social Services that following the "Baby P" case, they should be prepared to review their arrangements with other care agencies.
22. Only Warwickshire County Council set up an investigation. C&WPT refused on the basis that my elderly relative had not consented. I had raised that the only person seemingly having any influence over my elderly relative at this point was *** who was unlikely to encourage my elderly relative to consent to any investigation of *** behaviour. This was ignored.
23. I wrote to Independent Advocacy (whom I understand to be jointly financed by central government , by Warwickshire Social Services and possibly also C&WPT) openly raising my concerns about the training and qualification of their representatives and particularly raising what proper basis their employee *** had for overruling a consultant psychiatrist's assessment of my elderly relative's capabilities, and why *** had not informed FJ or me that she had sent an objection to the registration of the EPA.
24. FJ raised concerns that my elderly relative had not been properly advised as to what he options were.
25. I further raised that I was the only potential PoA who could not be suspected of financial exploitation, being financially secure myself and having defended my elderly relative from the earlier attempt to have her sectioned and steal her property; that in light of my cancer prognosis I had been determined to ensure that before my death my elderly relative would be financially protected and in sheltered accommodation with a full care package and that FJ and I had manifestly been working towards that end.
26. Instead, as a direct result of *** influence, my elderly relative was living alone in unsuitable accommodation which had no adjustments for her physical disabilities, surrounded by the same "friends" about whom concerns that they were financially exploiting her had been raised by independent third parties. Moreover nothing was being done to recover the money from her deceased husband's estate, notwithstanding that he had left her well provided for, notwithstanding that she had said that she could not afford a care package and plainly had no idea of what her potential resources were.
27. No suitable alternative PoA had been suggested and *** advice had left my elderly relative open to another attempt by the potentially financially exploitative relative to obtain control.

28. I received a rude and dismissive response from *** line manager which addressed none of the issues but merely said that he was satisfied with her conduct. I referred the matter to ***, the Chief Executive of Independent Advocacy, and received a response that again addressed not a single one of the issues raised by me but dismissively concluded that having had a discussion with *** was satisfied that *** had conducted herself appropriately.
29. The response from *** completely lacked transparency or accountability. It gave not a single piece of reasoning for her conclusion, let alone evidence. Even my general queries as to the training and remit of her staff were ignored by her. This is notwithstanding that a key finding of the 2002 Durham Report into the setting up of mental health advocacy services was that mental health advocates should be trained, supervised and accountable. The 2012 Royal College of Psychiatry report "Independent advocacy for people with mental disorder" also emphasised that independent advocates must have clarity of purpose, be accountable and have a proper complaints policy; also that the advocate should help the person know what choices they have and what the consequences are, not give false hope, not create dependency on the advocate nor do things that are not in the person's interest.
30. Further, the Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008 require IMHAs to have 'appropriate experience or training or an appropriate combination of experience and training'. It is up to the person or organisation appointing the IMHA to decide whether they demonstrate this. In making this determination, they must have regard to guidance issued by the Secretary of State. My query was perfectly reasonable yet *** refused to address it.
31. Plainly, post the Francis Report, NHS Trusts like C&WPT and related healthcare services such as Independent Advocacy show no willingness to engage with the representatives of patients, or to consider how general failings in services can be addressed or how complaints can be used to improve service delivery; no willingness to develop a culture that takes the concerns of individuals seriously and acts on them. The inadequate processes for dealing with complaints about healthcare provision continues, including attempting to evade any proper consideration of general concerns on the basis that they are not raised by a specific patient and cannot be investigated without a specific patient's consent.
32. <u>Factual/Experience 2</u>: In my LCNHS capacity have had recent cause in 2013 to make two complaints to the Royal Free London NHS Trust:
33. (a) That the Trust's "official procedures" for implementing their statutory duty under the National Health Service (Travel Expenses and Remission of Charges) Regulations 2003 to refund the cost of travelling to appointments for patients who were legally entitled to a financial refund on the basis of low income, were inefficient, demeaning and in breach of formal DoH guidance.
34. I had personally suffered intolerably rude and aggressive behaviour from the newly appointed finance manager ***, who freely admitted that he had no knowledge whatsoever of the statutory regulations pertaining to such refunds. Moreover I was present and witnessed a very distressing scene concerning an elderly wheelchair bound patient who had to be removed from the overcrowded tiny room where these payments are made because he was understandably becoming claustrophobic. When

the hospital porters attempted to return him when the room had cleared somewhat, he was refused entry on the basis that it was after 5pm and the facility was now closed. He was in clear need of the money and became very upset, but was simply dismissed.

35. Furthermore, the Trust is demanding data from patients to which it has no legal entitlement under the statutory regulations, and was refusing to pay the refund if not given this data and would not explain to what purpose the data was being used.
36. The Trust responded that it had no legal obligation to follow government guidance and could ignore it if it chose. It refused to address my concerns about the appalling and unacceptable treatment of the elderly patient on the basis of "patient privacy" and as I had not identified the patient they could not obtain his consent. They refused to answer my question as to how the newly appointed finance manager had been appointed to the post when by his own admittance he knew nothing whatsoever about the work.
37. (b) Separately, a few weeks ago, I raised concerns about lack of basic hygiene, in that it was official policy that phlebotomy department staff taking blood samples from numerous patients each working day should not wash their hands between patients but only after every third patient, just changing gloves in-between patients.
38. In fact I had never seen anyone in the department washing their hands in all the times I had been there, but in any event washing hands only after every third patient does not appear to satisfy general expectations of good hygiene nor indeed the statutory duties to prevent and control infection nor the duties under the Health and Social Care Act (2008) Code of Practice which requires that NHS bodies have in place appropriate arrangements for allocating responsibility to staff, contractors and other persons concerned in the provision of health care in order to protect patients from the risk of acquiring health care associated infections and imposes a collective responsibility for minimising the risk of infection and the general means by which it prevents and controls such risks. Also, there had already been a coroner's investigation into deaths caused by a surgeon changing gloves without also washing his hands - since 2010 it has been known that changing gloves without washing hands can be extremely dangerous – e.g. http://www.dailymail.co.uk/news/article-1334453/5-heart-patients-died-surgeon-John-Chen-Lui-Lu-changed-gloves.html
39. Again, the response from the Trust merely stated that I had misunderstood and if there was any spillage of blood, staff must wash their hands immediately. It confirmed that otherwise, staff only need to wash their hands for every third patient and otherwise only need to change gloves, applying gel. No attempt had been made to address the specific infection control issues that I had raised.

40. <u>General observations and recommendations:</u>

41. I regret to say that my general experience of all public sector organisations that supposedly handle complaints is that they are frequently staffed by badly trained, inefficient and often very rude people who have little interest or capability in carrying out a proper and accountable investigation, and feel they themselves are free from concerns of accountability for their own behaviour.

42. The Ombudsman system simply does not work.

43. A lot of time and public money is put into consultancy reports which produce recommendations but these are not carried out. Moreover, organisations feel free to wholly disregard guidance from Government departments.

44. Sanctions against badly performing public sector employees are usually wholly inadequate

45. As we have seen in the NHS, throughout the public sector poorly performing employees are merely recycled to other public organisations or promoted or given honours and there is little accountability. The complaints systems seem to me to be there ostensibly to provide a façade of democracy and accountability, whereas in fact it provides neither.

46. There is often a mechanism within an organisation's system for review by a higher body if the complainant feels that their complaint was inadequately addressed. In my direct experience, these rarely address any of the points raised but just send a response saying that they are satisfied that the investigation was carried out properly.

47. Frequently the organisation investigating the complaint prefaces its response by saying "We know that you will be disappointed with our response". In my direct experience, I always am. Not because they have not agreed with me, but because their forensic investigation has been wholly inadequate and they haven't even addressed the points raised.

48. In other instances, this is a common response because the public misunderstands the remit of the investigatory body. That is either because the system is far too complicated, or because the remit is too limited and doesn't actually address the problems being commonly experienced.

49. Complaints investigation systems need to be set up so that the complainant's concerns are properly investigated by qualified, well trained people who deal adequately with every aspect of the complaint and then have the powers to impose adequate sanctions. Currently, I cannot think of a single one that satisfies those basic requirements. Invariably they leave the complainant exhausted, frustrated and very annoyed that no changes have been made to prevent others experiencing the same inadequate or even dangerous services.

June 2013

Supplementary written evidence submitted by Jan Middleton (COM 35)

Summary:

A – The complaints system for Courts and Tribunals Services is a disgrace

B - The same tendency to evade responsibility and accountability exists as elsewhere in the public sector but is particularly unacceptable when it impacts on the ability to obtain justice.

C – The same propensity to seek to protect inadequate staff exists as elsewhere in the public sector

D – The behaviour of court and tribunal staff can impact greatly on the outcome of a matter but litigants/participants are not permitted to raise such issues during the hearing

E – There are no adequate sanctions, even where there is blatant discrimination and the behaviour is contrary to the Equal Treatment Bench Book and the natural rules of justice

F - The type of behaviour complained of also impacts very badly on the litigant in person. Concerns have recently been raised about the cuts in legal aid, for example the President of the Supreme Court Lord Neuberger expressing concern that it would start to undermine the rule of law. In my view, the abysmally low standards of behaviour experienced by me in the County Court and the LVT already undermine the rule of law, and the inadequate complaints system needs to be addressed urgently

1. Background:
2. This submission is from Jan Middleton.
3. I would like to appear before the Committee to give evidence, as on my observations too often those appearing are actually in receipt of funding from central government or commercial providers of services to the public sector, even when claiming to be commenting in an independent capacity and being set up as a charity.
4. My background is that I was a lawyer until negligent medical treatment by two lead clinicians *** at Charing Cross Hospital and Chelsea & Westminster Hospital throughout 2009 and 2010 which amongst other things left me with brain damage, vision impairment and permanently unable to work. ICHT admitted liability in 2013 and paid substantial damages, as well as sending me an unmitigated apology for the poor level of care that I had received. Medical investigation into continuing symptoms including unhealed wounds, aphasia, short term amnesia and post-operative infection continue to this day.
5. Factual examples
6. I live in a leasehold flat in London and had been in dispute with the freeholder and the Maintenance Trustee and property management company. Following the prolonged illness throughout 2009, which included several operations including two major ones of seven and twelve hours length, I contacted the Freeholder and the Maintenance Trustee and said that I was unfit to issue a pre-action protocol as I had previously indicated was coming to them following their refusal to have any discussions with me

to try to settle the dispute. I offered them the withheld money on a no liability bona fides basis pending discussions which I again exhorted them to hold with me to try to settle matters.

7. Instead, they told me that they would only accept payment if I agreed that it was in full and final settlement of all my issues, which included failure properly to maintain the property. Obviously I refused, and they then issued an Application in the London Lands Valuation Tribunal and court proceedings for forfeiture of my lease in the County Court. In the latter, £750 had been withheld by me as I had legal grounds for rejecting that the ten- fold increase in ground rent had been validly agreed
8. I was extremely ill during this time; however I knew of the Equal Treatment Bench Book and therefore requested both the Court and the Tribunal to make reasonable disability adjustments and adjournments. My GP provided medical evidence that I had impaired vision, brain damage, and as a result of the continuing post-operative infections was in a state of physical exhaustion; also that I was attending numerous medical appointments. (In late 2012 it was revealed that I had suffered a minor stroke in 2009 which had been hidden from me and that head scans taken at that time showed clear indications of problems that would result in the symptoms that I was experiencing e.g. dysphasia, amnesia, intermittent balance problems, etc.)
9. LVT: Initially, the LVT refused to adjourn its proposed date for a first hearing where the basis of the Application would be determined and directions issued. I was told that it didn't matter if I wasn't present because of illness prevented my attendance. I pointed out that it certainly mattered to me and that their approach was contrary to the Equal Treatment Bench Book provisions. I received a response that the Equal Treatment Bench Book did not apply to Tribunals. I made a complaint.
10. As a result, the initial hearing was adjourned. I was still very ill when I attended the re-arranged date. Part way through, the building was evacuated because of a bomb scare and I had to stand in a freezing cold street for half an hour. I was so ill after this that I was bed ridden for several days.
11. Some time later, correspondence from the LVT contained information which differed from my recollection of what had been said at the hearing and my own notes. I therefore asked for a copy of the notes taken by the London LVT panel member chairing it. I was told I couldn't have one – the notes were deemed private property, I had no entitlement to see them and anyway she had destroyed them.
12. In requesting further disability adjustment, my medical state and need for reasonable disability adjustments were confirmed in writing by my GP ,e.g inability to process information efficiently, intermittent aphasia, intermittent memory lapses; variable visual acuity; exhaustion; head pain; bleeding and discharging head wounds that would require changes of dressings etc. Evidence was also provided that I had been categorised by the DWP as being so seriously physically and/or mentally impaired that I was categorised as incapable of working.
13. I was then subjected to correspondence from LVT employees which I found totally unacceptable to the point of being rude and insulting in its tone and content. I made a formal complaint of disability discrimination.
14. This was inadequately investigated in my view, but as a result of my further complaint to Senior President Siobahn McGrath, it was revealed by accident that the Trustee

Representative at my Estate had not declared his conflict of interest as a London LVT panel member.

15. The matter was therefore moved to another region, Southern Region Cambridgeshire.
16. I made a formal complaint to Ms. McGrath about the LVT panel member's failure to declare an obvious conflict of interest. No investigation has yet taken place into this failure to declare his conflict of interest, or the subsequent attempted deception that he had no active role in the running of the Estate, notwithstanding that I have produced evidence that clearly shows this to be untrue. I have complained that he is unfit to be a panel member. No investigation of this very serious allegation has taken place.
17. Neither has Ms. McGrath registered that a discrimination complaint was made by me. I understood that all complaints of discrimination have to be centrally registered – if I recollect correctly, with the Ministry of Justice. Her response was that it is a matter for her to decide if it is a well- founded complaint after investigation, and it only has to be recorded if she finds that it is. The stupidity of such a system is self-evident. She was unable to undertake any investigation until the LVT matter was concluded, notwithstanding that I had raised that I was being subjected to bias.
18. The disability discrimination actually got worse once the matter had been transferred to the Cambridgeshire ***. Before transferring the matter, *** had adjourned the Application until I was well enough to participate. This was immediately overturned by***.
19. To cut a long saga short, amongst other things I received unacceptably biased correspondence from***, copied to *** colleagues, inter alia accusing me of "constantly complaining" because I had requested a review of the disability adjustments allowed as I was finding them inadequate; accusing me of making false and unsubstantiated complaints about his LVT colleagues etc. I was told that no adjustments for my visual impairment would be made at the hearing (I had requested that all documents should be in larger font) and if that was a problem for me then it was incumbent on me to find someone to accompany me to read the documents to me.
20. The piece de resistance by *** was his deliberately arranging a hearing and property inspection for a date after he had already been informed and received supporting medical evidence from my GP that I was seriously ill and awaiting emergency surgery. I was in the process of being diagnosed with pancreatic cancer and largely bed ridden, suffering from jaundice and vomiting, and awaiting the fitting of a stent to save my life pending major cancer surgery – Whipple Procedure, which is deemed by surgeons second only to transplant surgery.
21. Instead of being able to deal with the effects of this illness, I had to spend the night before the stent surgery doing a written application to the panel for the hearing that *** had nonetheless arranged, to reinforce my view that the hearing should not take place in my absence as I was medically certified as being unfit to attend it. Moreover, the Applicant had repeatedly been offered the withheld service charges on a bona fides no liability basis and therefore would suffer no financial detriment as a result of adjournment.

22. The application for adjournment was grudgingly accepted. No explanation has ever been given as to why it the hearing and inspection were arranged for a date which *** knew I would be unable to attend.
23. Nonetheless, the "property inspection" took place in my absence, although I could see part of it from my bed. Needless to add, the LVT panel were not taken around the parts of the Estate which had been described by independent third parties as "derelict in parts" and "in a very poor state of disrepair", but were steered by the RMG employee accompanying them to the more acceptable sections.
24. The LVT then refused to give me a copy of the notes taken at the hearing or any details of the presentation that had been made in my absence on behalf of the Applicant.
25. Throughout this matter, *** declared the medical evidence to be inadequate but would not give sufficient information as to how he deemed it inadequate. My GP could not understand what his issues were as what she had written appeared perfectly comprehensive to her and me. She wrote to him that she was unable to expand on her evidence without being told what further he required to know.
26. There was then further exhausting correspondence as the LVT insisted that the full hearing would take place in June 2012, despite having received medical verification that I would be having further major surgery in the intervening period which might be fatal and in no circumstances would I be sufficiently recovered by June. It was only adjourned after considerable and exhausting efforts by me.
27. All of this put unnecessary physical strain on me at a time when I was seriously ill, and a lot of the correspondence from the LVT was of a demeaning and humiliating nature. The LVT had no grounds whatsoever for suggesting that the medical evidence was inadequate or that I was exaggerating my symptoms to delay matters. I had repeatedly pointed out that given that the Applicants had no need to issue the Application as they had been offered the disputed sum on a no liability basis and refused it, they therefore could not claim to be financially disadvantaged by adjournment; also that I had repeatedly offered the same no liability payment pending any adjournment necessitated by my ill health; also that the Applicants had failed to comply with any of the directions, refused to meet with me to try to settle matters; etc.
28. I got so ground down by it all that even though the Applicants have been incapable of providing evidence that they even have locus, I paid almost £4000 demanded by them in settlement despite being firmly of the view that they had no legal entitlement – a view somewhat reinforced by the later decision in the *Paddington Basin* case. They then refused to accept this as settlement, demanding more.
29. In between the fitting of the stent and the Whipple operation, I complained about *** biased behaviour and breaches of the rules of natural justice and applied for consent to appeal. My application amongst other things raised a number of serious and pertinent legal points, and gave lucid reasoning for my views and gave evidence of the LVT's transgressions, for example: the LVT wrongly interpreted or wrongly applied the relevant law; there was a bizarre and irrational interpretation that amounted to a perverse decision; decisions were irrational and disproportionate; decisions were in breach of Article 6; decisions were in breach of Article 8; decisions were in breach of Article 14; there were numerous breaches of the Equality Act; there was a refusal to

observe the Equal Treatment Bench Book; the LVT Panel repeatedly failed to demonstrate impartiality; the LVT Panel repeatedly exhibited clear bias in favour of the Applicant, one of whose representatives at my Estate had not declared that he is a London LVT panel member; the LVT took account of irrelevant considerations, or failed to take account of relevant consideration or evidence, or there was a substantial procedural defect; the LVT had failed throughout to carry out its statutory duty to review the disability adjustments it made for me and responded to reasonable requests from me with unwarranted public criticism of me; the LVT acted in breach of the rules of natural justice.

30. As regards the medical evidence, *** had decided that I should obtain evidence of the same standard as in a family law case where £1,000,000 was in dispute. Apart from the fact that at this point the negligent medics were having severe difficulty in diagnosing the cause of my problems, my costs in an LVT would not be recoverable even if I succeeded. *** was therefore demanding that I spend thousands of pounds on experts' reports regarding vision, neurology, craniofacial surgery, post-operative infection etc when he had been unable to explain to my GP what he found inadequate about her evidence, and in the LVT only £1000 was still in dispute.
31. I received a response from President of the Upper Tribunal George Bartlett QC that consent to appeal was refused on the basis that the LVT's actions were "within the ambit of the LVT's discretion". No reasoning was given. When I enquired how things like disability discrimination and refusal to apply the Equal Treatment Bench Book were considered within the ambit of the LVT's discretion, I received a response that the President "did not consider it necessary to add to the reasons that he gave for refusing permission".
32. I referred the matter to Sir Jeremy Sullivan whom I understood to be the leader of the Tribunal judiciary and therefore reasonably thought that he might be interested in these abysmally low standards. I received a response that he was not prepared to comment and that I should obtain legal advice on appeal routes. If I was unhappy with George Bartlett's response, I should refer it to the Office for Judicial Complaints.
33. *** had been given the opportunity to comment on my concerns and responded saying that if I were dissatisfied, it was open for me to take out a judicial review. This of course would have potentially cost me tens of thousands of pounds in legal costs – about a remaining dispute of £1,000.
34. <u>County Court</u>: The same attitudes to disability adjustments prevailed in the County Court. My initial written request for disability adjustments was ignored.
35. Before a later hearing, I asked the court clerk if my request for reasonable disability adjustments had been acted upon and she literally did not know what "reasonable disability adjustments" meant or what the Equal Treatment Bench Book was. I asked her if she had received any training in equality issues and again she literally could not understand what this phrase "equality issues" meant, nor the phrase "equal access to justice".
36. Generally, and on a number of occasions, three of the court office clerks behaved in a wholly unacceptable manner, making derisory comments about my disabilities and generally being insulting and unhelpful, on the basis that because of my disabilities I "took up too much of their time".

37. One of these was the office manager, who on a day when I was extremely unwell and had a bleeding head wound, made me wait for over an hour to see her and then refused to deal with my query. She later wrongly struck out my claim and issued a limited civil restraint order contrary to the official guidelines and without any proper grounds. She also informed a judge before a later hearing that the appeal that I had lodged had nothing to do with the matter before him, whereas in fact it was entirely to do with it.
38. Matters were further unnecessarily complicated by court staff issuing conflicting Orders and then refusing to explain, a particular problem as I was suffering from cognitive impairment as a result of my head injury.
39. By the second hearing, I had obtained advice from HMCS Disability Officer who told me that as a reasonable disability adjustment under the Equal Treatment Bench Book, the court would supply a court employee to assist me in taking notes during the hearing. When I raised this with the judge, I was told that he was not agreeing to this as it would set a precedent and they hadn't sufficient staff.
40. I was too ill to attend the appeal hearing but submitted a written appeal. The bizarre response was that the civil restraint order was confirmed. Not a single one of the legal points that I had raised, about this and other matters, had been addressed.
41. I obtained pro bono legal advice from a leading disabilities discrimination barrister that I had strong grounds for a judicial review of the way that I had been treated. However, despite having no income other than welfare benefits and no remaining savings, I did not qualify for Legal Aid because of the equity in my flat. In order to have the behaviour of the court officials reviewed, I would have had to sell my flat to finance the judicial review.
42. In response to my local complaints, an officer responded purporting to have investigated when she had had no contact with me and not even obtained the details of the incidents complained of.
43. I then complained to the HMCS Complaints Unit about the court office staff. This was an utter farce in itself . After a few months of having my emails totally ignored, I finally managed to get through on their telephone line. The officer responding was rude, aggressive and hostile. I was told to send my complaint about the lack of response to the same general email address. I asked what the point of this when they were simply being ignored and requested a direct email address to an investigating officer. I was told that the Unit Manager *** did not think that this was necessary I raised that there was a six month limitation if I wished to take a discrimination action against West London County Court and accordingly I could not allow this delay to continue unabated, especially as it appeared to be deliberate. I added that as a person suffering from various disabilities and severe debilitating illness, it was untenable that I should have had to keep emailing and trying to get through on the telephone - these were unnecessary and exhausting difficulties caused by the inadequate organisation of the Complaints Team resources.
44. As a direct consequence of their refusal to process these queries and the complaint properly, I further had to exhaust myself in trying to find information from other sources.

45. I then found out that the head of the Complaints Unit *** had already been exposed in 2006 as being discriminatory and derisive towards a disabled man who was a litigant in person.
46. The Complaints Unit refused to make any disability adjustments for me and the designated investigation officer admitted that he had no training or understanding of equality law and that he knew nothing about the Equal Treatment Bench Book, so it was reasonable for me to conclude that he was unlikely to be able to investigate my complaints of disability discrimination by court officials. It was equally ridiculous to expect him to investigate a complaint about the conduct of his manager *** in refusing to make reasonable disability adjustments for me.
47. No progress was made and no proper investigation ever took place.
48. In a further attempt to delay and exasperate me, HMCS Data Access and Compliance Unit refused to respond to legitimate FOIA and DPA requests and I had to make a complaint about that.
49. I complained to the Office for Judicial Complaints about the rude and discriminatory comments to me of one of the West London County Court judges and the failures to make any allowances for someone who was clearly ill and injured.
50. OJC were unable to consider parts of my complaint as it was outside their remit. On another issue within their remit, they were unable to give me an extension of time to provide further information at a time when I was too ill to respond, on the basis that they "could not leave requests for information open-ended otherwise (they) would have no means of measuring when it is appropriate to apply the Judicial Discipline Regulations to progress a matter."
51. Part of the delay had been caused by the failure of the Court to supply the transcript requested by me – indeed I never received this. I see no reason why complainants should have to obtain this at their own expense as it would be more appropriate for OJC to obtain it. It appears to be another means of deterring complainants.
52. My query to HMCS as to which body assessed the quality of service provided by County Court staff now that HM Inspectorate of Court Administration no longer existed, received no response other than an acknowledgement that the email had been received.
53. I contacted the Administrative Justice and Tribunals Council to be informed that they had no remit in such matters and could not advise.
54. I complained in the strongest terms about the abysmally poor general standards to HMCS, copying in Ken Clarke who was then Minister of Justice, Jonathon Djangogly and Lord McNally. I received no response, just read receipts.
55. My MP wrote to the Ministry of Justice on my behalf about this entire farrago and we received a response from Crispin Blunt on behalf of Jonathon Djangogly, in which the former's ignorance of court procedures was manifest and which contained a number of factual errors. Even my MP termed it unhelpful. As I recollect, the follow up letter forwarded by my MP received no further response.
56. My letter to the Disabilities Minister Maria Miller was ignored.
57. I found it impossible even to find out who was designated with the responsibility of ensuring that the Courts and Tribunals Services adhered to the Equality Act and followed the Equal Treatment Bench Book.

58. I contacted Disability Law Service who were unable to assist as they did not have the resources. EHRC helpline confirmed that the behaviour complained of amounted to disability discrimination and pointed out that it also potentially amounted to disability harassment but could give no further input.
59. In October 2011 I received a response from a senior caseworker at the Complaints Unit to the complaint first made by me several months earlier. His response appeared to have been prompted only by the correspondence to ministers.
60. Yet again, there were numerous errors of fact in this letter. Also, whereas court officers now accepted some of my views about what would have been an appropriate response, no explanation was given for their previous behaviour towards me and certainly no apology was given.
61. After some months delay, HMCS Data Compliance finally responded to my query as to who had overall responsibility for the standards of service, which for reasons known only to themselves they had earlier refused to give a response. They couldn't even get that right, informing me that it was Peter Hancock rather than his proper name Peter Handcock.
62. I received no response from Peter Handcock to my email about abysmally poor standards. I see from the internet that he has now been awarded a CBE.
63. I also copied it to Bob Ayling, from whom I received only a read receipt. I see that Mr. Ayling is now the independent chairman of the HMCTS Board.
64. In reading through my accounts of non-response to legitimate and proportionate concerns about serious issues of disability discrimination and generally poor standards in the Courts and Tribunals, and the inadequate means of raising concerns and complaints and having them properly investigated, it is pertinent to bear in mind that I was extremely ill throughout this farrago, and my illness has been exacerbated by the behaviour complained of and the lack of proper means of investigating complaints. It is also pertinent to bear in mind that despite my illness which included cognitive impairment, the fact that I had been a qualified lawyer means that I had ability far beyond that of the average complainant to pursue my complaints and try different means of getting them addressed. Many complainants do not have such a background and are simply left stranded without any proper investigation of their concerns.
65. The type of behaviour complained of also impacts very badly on the litigant in person. Concerns have recently been raised about the cuts in legal aid, for example the President of the Supreme Court Lord Neuberger expressing concern that it would start to undermine the rule of law.
66. In my view, the abysmally low standards of behaviour experienced by me in the County Court and the LVT already undermine the rule of law, and the inadequate complaints system needs to be addressed urgently.

67. <u>General observations and recommendations:</u>

68. I regret to say that my general experience of all public sector organisations that supposedly handle complaints is that they are frequently staffed by badly trained, inefficient and often very rude people who have little interest or capability in

carrying out a proper and accountable investigation, and feel they themselves are free from concerns of accountability for their own behaviour.

69. The Ombudsman system simply does not work.

70. A lot of time and public money is put into consultancy reports which produce recommendations but these are not carried out. Moreover, organisations feel free to wholly disregard guidance from Government departments.

71. Sanctions against badly performing public sector employees are usually wholly inadequate

72. As we have seen in the NHS, throughout the public sector poorly performing employees are merely recycled to other public organisations or promoted or given honours and there is little accountability. The complaints systems seem to me to be there ostensibly to provide a façade of democracy and accountability, whereas in fact it provides neither.

73. There is often a mechanism within an organisation's system for review by a higher body if the complainant feels that their complaint was inadequately addressed. In my direct experience, these rarely address any of the points raised but just send a response saying that they are satisfied that the investigation was carried out properly.

74. Frequently the organisation investigating the complaint prefaces its response by saying "We know that you will be disappointed with our response". In my direct experience, I always am. Not because they have not agreed with me, but because their forensic investigation has been wholly inadequate and they haven't even addressed the points raised.

75. In other instances, this is a common response because the public misunderstands the remit of the investigatory body. That is either because the system is far too complicated, or because the remit is too limited and doesn't actually address the problems being commonly experienced.

76. Complaints investigation systems need to be set up so that the complainant's concerns are properly investigated by qualified, well trained people who deal adequately with every aspect of the complaint and then have the powers to impose adequate sanctions. Currently, I cannot think of a single one that satisfies those basic requirements. Invariably they leave the complainant exhausted, frustrated and very annoyed that no changes have been made to prevent others experiencing the same inadequate or even dangerous services.

June 2013

Written evidence submitted by the Citizens Advice Bureau (COM 36)

Thank you for your invitation to contribute to the PASC as part of your inquiry into complaints handling. Citizens Advice are seeing an increasing need for clients and advisers to be able to complain effectively, and there is an expectation that this will increase as welfare reform sees more decisions made by personal advisers using 'discretion'. We are also seeing increasing numbers of complaints to our consumer helpline. Please see below for evidence from a variety of areas within the Citizens Advice service, where we have been dealing with complaints.

Evidence from Citizens Advice Bureaux

The evidence reports submitted to Citizens Advice from Bureaux tend to focus on the issues that give their clients cause for complaint, rather than their experiences of the complaints procedures – at least certainly in respect of public services. We have more evidence on complaints about the financial sector and the use of the financial ombudsman.
An adviser will often end a report to us with 'advised the client to consider complaining and what the complaints procedures are'.

We have the most information on government complaints about HMRC (though fewer than a couple of years ago) - primarily because the complaints process are often important in resolving financial issues such as overpayment problems. In relation to DWP and Jobcentre Plus (JCP), clients are far more likely to appeal an entitlement decision than to complain – getting the money right naturally being of primary concern. Advisers often find that by the time the issue is resolved through the appeal or reconsideration process, the client has little energy left to continue through the complaints process. Other clients are worried about complaining because they fear that it will affect their claim or the relationship with their personal adviser.

To supplement the evidence reports submitted to Citizens Advice, we asked a number of advisers to provide us with more detail of their recent experiences of making complaints to DWP and HMRC. The following things emerged:

HMRC, Tax credits

- **Delays**: Advisers felt that problems with complaints occurred in the context of long delays elsewhere in the services e.g. until recently appeals against tax credit decisions were taking six months to process. Advisers felt that their complaints originated from mistakes that appeared to result from backlogs of work putting pressure of staff to deal with cases as quickly as possible.
- **Process**: Until the initial complaint has been responded to, the complainant cannot escalate it to Independent Case Examiner or the Parliamentary and Health Service Ombudsman. Evidence also suggests that there are not clear procedures to ensure that where there is more than one issue included in a letter, it can be passed to each relevant department.
- **Complaints were frequently not deal with as complaints:** Where letters included more than one issue – i.e. a complaint but also a request for an overpayment to be reconsidered it would be sent to

the reconsideration department and not dealt with as a complaint at all. This means that they are not responded to within the required 28 day period, are not logged and learning for future quality of services is limited. In one case the adviser submitted an appeal against a tax credit decision but also a complaint about the treatment of the client. The tax credit adviser told the bureau that it was only being dealt with by the appeals team and without the challenge of the CAB adviser this would not have been logged as a complaint at all.

- **Resistance to accepting complaints:** Advisers felt that some HMRC staff were resistant to considering complaints. In one case an adviser attempted to complain about a compliance officer who had been rude and unhelpful to them on the phone, they received no acknowledgement of, or response to, the complaint, for four months, at which point Citizens Advice raised the issue with senior HMRC staff. Even then though the issue was resolved, there was no apology, something that is crucial in satisfactory complaint handling.
- **Standard, depersonalised responses:** In many cases clients felt that the responses to their complaints were too standard or template, and did not sufficiently relate to the substance of the complaint. An adviser reported that this felt like the clients are not treated like individuals.
- **The general impression is of an evasive approach to complaints.**
- **Temporary resolution:** Advisers reported that they'd seen a number of cases where tax credit complaints were resolved only to find that a year or two later the overpayment which was the subject of the complaint, had reappeared (HMRC). In another case, a JCP customer had been told that following her complaint she did not have to deal with a particular personal adviser. However, after a period she found that it had later been forgotten.

DWP

- **Complexity preventing complaints:** One adviser cited the complexity of the benefits system as making it harder for people to complain and putting off those with grounds to complain. Claimants who were confused by the system found it hard to know how to describe problems.
- **Delays and lack of acknowledgement of receipt:** Advisers reported that two months was quite a normal period of time in which to acknowledge a complaint although the target is seven days. One adviser reported having recently submitted around 20 complaints mainly about appeal delays, but had only received acknowledgements for two, despite them being clearly marked as complaints.
- **Resolution and compensation payments:** Advisers reported that they were often not told when cases had been resolved, and that the case for special payments are not considered when they are supposed to.

Citizens Advice training on Delays, complaints and administrative issues

As a result in seeing an increase in complaints, particularly about Jobcentre Plus, the Citizens Advice specialist support team decided to create a course to equip Bureaux advisers to navigate the complaints procedure.

The course has been run three times and a fourth is due to run next month. Feedback on the course has been good although demand is not particularly high. Citizens Advice specialist support teams are increasingly suggesting that advisers use the Independent Case Examiner or the Ombudsman, particularly for complaints about JCP because of recurring problems. An example of this is the poor

advice being given to lone parent EEA nationals to claim income support rather than Jobseeker's Allowance. This is not a new issue and Jobcentre Plus have previously stated that they would deal with it by training, yet we still regularly see examples where the wrong advice is given to the severe detriment of clients. The specialist support team have also picked up an indication that the Jobcentre Plus complaints procedure is often not thorough enough until the complaint goes to the highest level. They see that advisers can help the process by formulating complaints more clearly and by taking the 'emotion' out of the issue. However, Jobcentre Plus encourage people to make their initial complaint by phone and it is all to easy for the client/adviser to be 'fobbed off'.

Consumer complaints

Our experience as providing the Citizens Advice Consumer Service gives us valuable insights into the handling of complaints in the private sector, both the good and the bad. It is also interesting to see how social media is impacting on complaints in the private sector – something which we have not seen breaking through into public sector complaints yet.

We received 652,762 complaints from consumers to our Citizens Advice consumer service helpline in the year to March 2013. What we do not know is how many people had cause to complain but did not, nor do we know much about the qualitative consumer experience of complaining – including how many of them are resolved to the consumer's satisfaction. A wider picture of consumer complaints can be gained from the number of complaints to regulators (Ofcom, PhonepayPlus, Ofgem, the FCA etc) and complaints made directly to companies who either voluntarily publish their figures or are required to publish them (authorised FCA firms, for example). Ombudsmen also publish data on complaints.

There is a new front opening up in consumer complaints with consumers taking to Twitter and Facebook to complain to firms' social media presence, sometimes with more success than following the official complaints process.

While firms have invested a great deal in making purchasing as easy as possible, our impression is that significantly less resource has been invested in streamlining complaints. Extensive behavioural research on aspects from the design of physical stores to streamlining the online purchase and delivery processes has led to innovations like Amazon's one-click purchasing. However, our instinct is that significantly less resource has been invested in streamlining complaints to make them as easy as possible. Some of the lessons learned in encouraging purchases could probably be applied to complaints but our sense is that many firms would rather discourage complaints, or are not keen to encourage them.

Complaints should be seen as an important resource for firms. They highlight where products have inherent flaws, where sales processes are going wrong or can even elicit new product ideas and innovations. Many firms perform excellently on complaints, but the sheer number of disgruntled customers who approach the Citizens Advice consumer service illustrate that a significant number do not. We hope to investigate some of these issues as part of a flagship project entitled 'consumer rights and wrongs'.

We hope that this is information is useful to the PASC in their inquiry. Please do not hesitate to contact us should you have further queries.

July 2013

Written evidence submitted by Ann-Marie Smalling-Small (COM 37)

Complaints: do they make a difference? *NO*

Complaints to Government departments doesn't make any difference, they are a waste of my time, energy and money. I have made 8 appeals/complaints, send over 2000 emails and letters with evidence of Forgery/corruption/racial discrimination by Home Office MEU Senior Officers to the Administrative court, the British High Commission, AIT, UKBA and their complaints department, and the Ombudsman to which all have been dismissed or returned citing 'outside our remit' yet they all closed my complaint with False Outcome 'CO/32692/04' dated Sept. 17, 2004 which doesn't match my documents and neither court nor judge can verify, yet, no one wants to redress my complaint even with concrete evidence.

As with the failings at Mid Staffordshire hospital, complaints about Senior officials are not taken seriously and either dismissed or covered up as with my case and after exhausting all avenues available, I complained to the former Ombudsman, Ann Abraham who stated in her letter of May 23, 2007, that "Comments by Immigration Officer is not in my files" yet used False court order to close my case, therefore, it makes no difference making a complaint.

1. What objectives should Ministers adopt when considering how complaints about Government and about public services provided by Government are handled?

No one is outside the law, whether Senior Official or individuals and complaints about corruption/abuse by Senior Officials should be investigated and not ignored or covered. Personal contact with the complainants via telephone or face to face and responding whether by emails or letters to their queries.

What gaps in the complaints systems exist; and how should ministers ensure they are addressed?

Complaints against public authority e.g. UKBA is not investigated properly and while the UKBA can produce false court document which went unnoticed for 8 years with over 2000 emails and letters went unanswered, the complainant cannot see the documents produced by UKBA in complaint. A special inspector can view complaints dealt with and contact the victims to see that their complaint has been dealt with according to law.

2. How effectively do Government departments and public service providers use complaints to improve the service provided?

They don't.

Who should be accountable for leadership and governance of complaints systems across government and its agencies?

An Independent Inspector who will report to board members

How should data on complaints be gathered and monitored?

Complaints should be gathered from all public agency and monitored by an Independent inspector.

How should information about complaints be used to lead and drive improvement?

Complaints about e.g racism should be made priority and address outright not shoved under numerous immigration laws as if it doesn't exist then delete/destroyed to hide the high volume that exist in government department.

What do complaints cost; and how much money could be saved by learning from complaints?

Millions.

3. How quickly do complaints systems deal with legitimate grievances and

provide redress?

Complaints are dealt with within 6 weeks to 3 months and redress can go up to 9 years and on.

4. How easy is it to make a complaint about a Government department or agency,

and how could this be improved?

Very difficult to complaint about a government agency as no one believes you even with evidence. E.g. evidence of forgery/corruption are not to be ignored/covered and is to be dealt with straight away.

Can people easily find their way around complaints systems?

Very difficult.

Do complaints systems provide proper access for vulnerable,

disengaged, or excluded groups?

No.

How welcome are complaints to government departments and agencies, compared to complaints to a department store or to a mobile phone company for example? What should government learn from the private sector?

Complaints to government departments is as if I should not be complaining at all and wasting their time. Most government staff are rude and obnoxious while mobile company/private sector is always polite and courteous and eager to assist and deal with your complaint. Government staff needs customer service training.

Do complaints systems succeed in making public services and government departments more accountable and responsive to service users?

No.

5. Do complaints-handling systems achieve the right balance between nonjudicial

and judicial investigations and remedies?

What is the right balance?

How can ministers reduce litigation costs and defensive behaviour

in favour of informal redress and openness?

Person contact with victims and sympathise with their complaints by addressing their issues

6. How aware are service users of the various ombudsmen (such as the Local

Government Ombudsman, Financial Ombudsman and the Housing

Ombudsman)?

How do they coordinate their respective roles?

7. What lessons for complaints handling in the NHS are emerging from the

Francis Report into failing at Mid Staffordshire Hospital?

Complaints about Senior Officials in Government department are not taken seriously and rejected instantly without investigation.

Which lessons have relevance to complaints handling processes elsewhere in Government and public services?

Complaints by individual about Senior Officials behaviour are ignored or covered as per Home Office MEU boss who used False court order to removed me from the UK when I reported their racial behaviour to the Adjudicator who grant me indefinite bail but 4 months later, they just create new file under incorrect date of birth with false Outcome and brutally removed me from the UK.

8. How well do Ministers and senior officials deal with complaints raised by MPs

on behalf of constituents?

Not well and they make the Complainant feels as if you are a snitch.

What do Ministers and senior officials learn from complaints and how do they use complaints as feedback on departmental policy and implementation?

9. How should complaints about complaints systems be handled?

Complaints should be recorded and data used to improve complaints systems.

How should departments and government as a whole monitor performance of complaints handling systems?

Engaged the services of an Independent Inspector.

Do tribunals systems work effectively; and how could they be improved?

No system work perfectly but constant monitoring can help improved the system.

S**hould there be a single point of contact for impartial information on where to make a complaint or to seek redress? How should this be provided?**

Yes, it would be easier on victims to have a single point of contact and to seek redress but not wise as Parliament gives the Ombudsman discretion to choose cases with freedom that she can close case with errors without redress like mine. I requested my court documents from Freedom of Information and noted that they are not mine and since the Ombudsman is the last stage of appeal, it would not be logical to have a single point of contact as if the Ombudsman decide to close your case and remain closed even with her errors, complainant won't get any justice or redress when the Ombudsman staff side with Senior Officials and ignored concrete evidence. There should also be an Independent complaint department with independent investigators and inspectors to review complaint and remedies used. Who inspect the Ombudsman's complaints and remedies used? Is there a board that goes over the Ombudsman's decisions when the complainant not satisfied? As you can see from the attached 3 letters from the Ombudsman dated Feb. 19, May 23 & closing Sept. 6, 2007 that no effort was put into investigating my complaint.

10. How do other countries handle complaints and what could the UK Government learn from them?

I complained to my government that I was brutally removed from the UK on False court order and now they are writing Home Office about it. The Ministry of Foreign Affairs called me (personal contact) requesting further information while when I reported my complaint to Dr Tony Wright MP, I never heard or got a letter or email enquiring if I was satisfied with the outcome of my complaint to the Ombudsman.

July 2013