

Annual Report 2005-06

Making a difference



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

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

Our vision is to:

- make our service available to all who need it
- operate open, transparent, fair, customer-focused processes
- understand complaints and investigate them thoroughly, quickly and impartially, and secure appropriate outcomes
- and share learning to promote improvement in public services.

The values which underpin everything we do are:

Excellence

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

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

Leadership

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

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

Integrity

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

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

Diversity

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

- we respect others, regardless of personal differences
- we listen to people to understand their needs and tailor our service accordingly

- we promote equal access to our service for all members of the community.

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

Annual Report 2005-06

Session 2005-06

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

Ordered by
The House of Commons

to be printed on
12 July 2006

London: The Stationery Office

HC 1363
£16.25

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Foreword:

putting customers and patients first

People want high quality public services that are administered well and built around their needs, not organisational convenience. But when things go wrong they also want them to be put right speedily and appropriately.

Complaints matter enormously to the people who make them and the way they are dealt with makes a significant difference to people's lives. Public service providers should

also welcome complaints as an opportunity to use the learning arising from them to improve overall standards of service.



Ann Abraham
Parliamentary and Health Service
Ombudsman

Government departments: engagement and defensiveness

My role does not stop at putting things right for individuals. I am also keen to work with government departments and agencies and NHS bodies to help improve public services for the benefit of all users. In addition to making recommendations, providing information and analysis from investigating complaints is a powerful lever for reform. But for this to be effective, there must be constructive dialogue and active engagement by the bodies concerned.

Government departments usually show a welcome willingness to respond constructively to my investigations and reports and to accept my findings. They have worked with my Office and other stakeholders to tackle underlying, persistent problems and to improve local complaint handling. This is crucial. I have always said that it is best for complainants if their complaints are resolved effectively at local level; the Ombudsman should be the last resort.

My Office has worked this year with the Department of Health and the Healthcare Commission to deliver our shared commitment to improved complaint handling and local service improvement. We recognise that there is a long way to go to achieve effective, outcome-based complaint handling at local level, but the joint development this year of an NHS Complaints Standard is an important

step towards this. Similarly, I welcome the Department's intention to integrate the handling of health and social care complaints, outlined in the Department's White paper, *Our health, our care, our say* (Cm 6737 of January 2006), and which was one of the recommendations in my report on the NHS complaints system, published in March 2005. We are also providing advice to the Healthcare Commission in addressing their backlog of complaints at the independent review stage.

HM Revenue and Customs (HMRC) has also worked constructively with my Office on the issue of tax credits. My report *Tax Credits: Putting things Right* (June 2005) considered complaints about the workings of the Child and Working Tax Credits system. Many people on low incomes were suffering financial hardship because of the design of the tax credit system and the way that system was being delivered. I concluded that there were important lessons for all public bodies about seeing things from the customer's perspective when designing and implementing new policies and systems. Although reluctant to accept my findings of maladministration, HMRC is now responding with some substantial changes to the administration of the system. We also agreed new arrangements for handling complaints about tax credits, which will improve the service complainants receive.

I have encountered much less positive engagement on certain issues from other departments, to the point that I had to report on two occasions to Parliament about injustice caused by



maladministration that the Government did not intend to remedy. *A Debt of Honour* (July 2005) reported my investigation into complaints about the ex gratia compensation scheme for British groups interned in the Far East during the Second World War. The Ministry of Defence (MOD) initially rejected two of my recommendations, including a recommendation that it should review the operation of the scheme. Subsequently, and immediately before the Public Administration Select Committee (PASC) took evidence on the scheme from the Minister, the MOD accepted that inconsistencies in the way the scheme was managed had occurred. Ministers have now come to similar conclusions to mine, and the Government proposes to expand the eligibility criteria. I welcome this, and hope it will allow a full reconsideration of the position of those civilian internees whose applications had been refused. I am grateful to PASC for the support it provided, although I am concerned that it took their intervention to achieve progress.

In *Trusting in the Pensions Promise* (March 2006), I found that official information provided over many years about the security of final salary occupational pensions was inaccurate, incomplete, unclear and inconsistent. Having relied on this information, occupational pension scheme members in schemes that had wound up with insufficient assets were experiencing hardship and distress. The Department for Work and Pensions (DWP) has not accepted my findings or the main recommendations of the report and its response continues to be negative. I find this extremely disappointing, as no doubt do the pension scheme members affected.

Government departments may legitimately contest recommendations, having properly considered the public interest and the cost of implementing them. However, it is inappropriate for a body under investigation to seek to override the judgment of the independent arbiter established by Parliament to act on its behalf. PASC has taken a strong interest in these issues. In its own report on *A Debt of Honour*, the Committee concluded,

“The entire basis of the Parliamentary Commissioner Act 1967 is that it is possible for a measure to be legal, but to be maladministered ... There is ample evidence to support the Ombudsman’s finding of maladministration.”¹

Throughout this Annual Report, we highlight examples of helpful and constructive engagement by public bodies and give instances where policy or practice has changed following a complaint. These are contrasted with examples of unnecessary defensiveness, a negative attitude to complaints and tardiness in remedying problems.

Making it simpler for people to complain

Navigating through the system is not always easy for people who want to complain about a service. There is a plethora of complaints systems across public services and little in the way of consistent standards for handling complaints, even within some departments. There is also an array of different bodies to complain to – Ombudsmen, tribunals, complaint handling agencies and the courts. For complainants, even distinguishing between the jurisdictions of different Ombudsmen is not always simple. Users therefore need greater clarity about the administrative justice landscape.

Promoting a common and accessible framework for complaints across government departments, agencies and the NHS is a priority for my Office. An example of progress this year is our work with the Department of Health and the Healthcare Commission to draw up a new standard for complaints handling.

We have continued to work with other bodies to simplify joint working where a complaint crosses different jurisdictions. The Local Government Ombudsmen and I have collaborated closely on a number of investigations that span health and social care. Jerry White, one of the Local Government Ombudsmen, and I also reported on our investigations into the case of Mr and Mrs Balchin [C57/94]. Mr and Mrs Balchin had suffered financial loss and experienced



¹ House of Commons Public Administration Select Committee, *A Debt of Honour*, First Report of Session 2005-06, HC 735



Improving public services

One of the two key aims set out in our *Three-Year Strategic Plan 2005-08* was to share our knowledge and experience to contribute to improvements in public service delivery. My Office has a unique overview across government departments and agencies in the UK and the NHS in England. This informs our work with other Ombudsmen to identify and promulgate good practice in complaint handling. We have worked closely with the British and Irish Ombudsman Association, which I have chaired for the past two years. I was very pleased to host the visit of the European Ombudsman, Nikiforos Diamandouros, to the UK in November 2005. Ombudsmen and other complaint handlers in the UK welcomed the opportunity to share our various experiences and perspectives on complaint handling and good administrative practice.

My Office is currently working to establish principles of good public administration which can be used in the work of the Office and which I hope will be endorsed by all those who are responsible for both public service delivery and for formulating the policies which underpin those services.

New challenges

We have drawn on our considerable experience of complaints handling to work with the Home Office and the Independent Police Complaints Commission on the introduction of the

considerable distress because of the actions of the Department for Transport and Norfolk County Council. Both Jerry White and I upheld Mr and Mrs Balchin's complaints to us and we were pleased that the Department and the Council paid Mr and Mrs Balchin a total of £200,000 in recognition of the effects upon them of the maladministration that had occurred. The relevant legislation requires the Ombudsmen to publish separate reports, but it is only when our reports are read together that the full story can be understood. For this reason each report has the other annexed to it. This case clearly showed the need to reform the legislation covering working arrangements between public sector Ombudsmen. I therefore welcomed

the Cabinet Office consultation in autumn 2005 on proposed legislative changes that would allow this. I look forward to this becoming a reality.

As well as making it easier for Ombudsmen to work together on complaints which span more than one jurisdiction, we want to increase awareness of our service among certain parts of the population where we know it is low, especially among ethnic minority groups. This year, we have started to develop an equality and diversity strategy to help improve our understanding of these issues. We are monitoring the demographic profile of complainants to help inform our work and to reach all those groups who need our service.

Victims' Code, launched by the Government on 3 April 2006. The Code gives victims of crime a statutory entitlement to a minimum standard of service from Criminal Justice System agencies. It also gives me responsibility for assessing complaints about breaches of obligations under the Code, where victims have been unable to get their complaint resolved satisfactorily by the agency concerned. This new area of work will bring its own challenges as we work with other public bodies which have never before found themselves within my jurisdiction.

The final phase of the transfer of responsibility for the healthcare of prisoners from prisons to the NHS culminated in the final devolution of commissioning responsibility to Primary Care Trusts from 1 April 2006. This is another new area of work for my office. We will need to work closely with others and, again, we will be seeking information to help us in our investigations from those who have had no previous contact with this office.

Continuing care

This year, we continued to work with the Department of Health and with Strategic Health Authorities (SHAs) to deal with complaints about the way funding for long-term care has been handled. We shared with the Department our checklists for the investigation of complaints, drawn from our experience of investigating many retrospective continuing care complaints. The Department made these checklists available to SHAs to assist them when planning and conducting continuing care

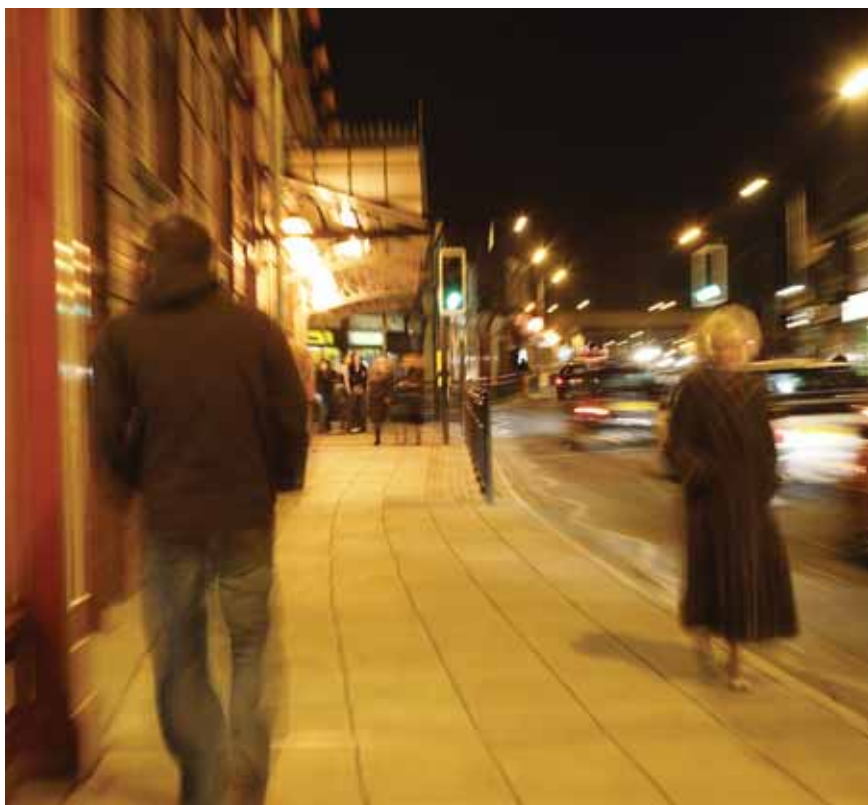
assessments and reviews. I am pleased that the Department has now published their consultation document on a national framework for NHS continuing care and NHS funded nursing care in England. A national framework was one of the recommendations of my two reports on the subject in 2003 and 2004.

Developing our service

The other main aim in our strategic plan for 2005-08 was to deliver a high quality complaints handling service to customers. Our three-year plan was matched by a three-year financial settlement from the Treasury for the first time. This provides us with the

stability in our resources to plan and develop our service to meet our customers' needs. This year, we implemented a completely new, and more customer-focused, approach to handling complaints. At the same time, we successfully introduced a new computer system to help us manage our everyday work more efficiently and to provide better management information.

These extensive changes initially increased the time taken to investigate cases. However, our action plan to reduce the peak of cases which built up in the first half of 2005-06 bore fruit in the last six months of the year. We concluded 25% more cases than in the previous year, reduced the overall



number of cases in hand and reduced the number of cases awaiting allocation to an investigator. We now need to work on the time it takes to complete individual cases, on which we disappointingly failed to meet our customer service standards this year. We are achieving positive responses to the new arrangements from customers through our satisfaction survey. I was particularly pleased to receive a letter from Mr A, who, despite not having his complaint upheld, said:

“It would [have] been obvious to you in drawing your conclusions, that I would not be ‘enthusiastic’ about the result of this report, however, you have played your part without bias in either direction and you have worked honestly in the cause of justice and for that I have nothing but praise.”



I would like to thank all my staff for their commitment and hard work during 2005-06. They have successfully introduced new ways of working and dealt with a large number of cases while maintaining the quality of their work. Our focus for the coming year and beyond is to ensure that our service becomes as efficient as possible. I believe that we have laid the foundations for this during the past year. In 2006-07, we will build on this year’s achievements to accomplish our objectives of increasing our efficiency, quality and influence for the benefit of our customers, of taxpayers, and of the users of public services.

Ann Abraham
Parliamentary and Health Service
Ombudsman





“We had received a large number of complaints about the operation of the Child and Working Tax Credits system. These mainly concerned the way the Revenue handled the recovery of overpayments, the impact of which was felt hardest by poor families with children and people on low incomes.”

Government departments and agencies: improving customer service

In 2005-06, we reported on 1,715 Parliamentary cases and a further 15 were discontinued at the request of the complainant.

Figure 1
Parliamentary cases accepted and concluded in 2005-06

	In hand at 1.4.05	Cases accepted for investigation in year	Cases reported on in year	Discontinued cases	In hand at 1.4.06
Parliamentary	1,012	1,853	1,715	15	1,135

A single case referred to us on behalf of a complainant may include complaints about more than one body – for example, a complainant might complain about the actions of the Disability and Carers Service and Jobcentre Plus. It is therefore important that, as well as recording

the number of cases we report on, we also record the number of bodies complained about.

The following table shows the highest number of Parliamentary complaints by body which we reported on in 2005-06.



Figure 2
Highest number of Parliamentary complaints by body 2005-06

	Accepted for investigation in year	Reported on in year	Percentage upheld in full or in part	In hand at 1.4.06
HM Revenue and Customs – tax credits	404	299	90%	309
HM Revenue and Customs – other	144	114	30%	101
Jobcentre Plus	263	221	52%	147
Child Support Agency	209	180	83%	177
Pension Service	97	111	45%	39
Immigration and Nationality Directorate	95	75	88%	54

As in previous years, a small number of departments or agencies has accounted for the majority of complaints that we have investigated. For example, HM Revenue and Customs and the Child Support Agency continue to generate large numbers of complaints despite having their arm's length complaints review tier. Many of these complaints would never have got as far as the Ombudsman if they had been handled properly in the first place. We continued to work with departments and agencies to support them in making improvements to their service and to their handling of complaints.

We do not uphold all of the complaints we receive. In 2005-06, we fully or partly upheld 54% and did not uphold 46% (see figure 4 on page 23). In some cases, we find no evidence of maladministration and conclude that the department or agency handled the complaint itself entirely properly. In other cases, however, we see the same types of issues emerging, including delays in processing complaints, poor

communication with customers and the provision of misleading information or advice. These are sometimes compounded by poor complaint handling at departmental level.

Most of the time, departments accept our findings and act to resolve the problems. However, this year we have encountered defensiveness from some departments and a reluctance to remedy problems in relation to certain issues. This was the case with the Ministry of Defence, initially, over *A Debt of Honour*, concerning the ex gratia compensation scheme for British internees in the Far East during World War II, and with the Department of Work and Pensions in relation to our report on occupational pensions, *Trusting in the Pensions Promise*. This contrasts with the positive engagement by the Revenue in addressing the continuing problems with the Child and Working Tax Credits system, despite their unwillingness to accept some of the findings of maladministration.

Handling complaints: defensiveness or engagement?

A Debt of Honour

We published *A Debt of Honour: the ex gratia scheme for British groups interned by the Japanese during the Second World War* (HC 324) in July 2005. The report sets out the results of our investigation into a complaint made by Professor Jack Hayward, who was interned with his parents in early 1943. Professor Hayward's complaint was one of a number of complaints about the same matters received by the Ombudsman.

The Ministry of Defence (MOD) compensation scheme was devised to fulfil a "debt of honour" to those who were interned because they were British and who endured inhuman treatment and suffering at the hands of the Japanese. Complaints about the scheme related to the MOD's decision to introduce a new eligibility criterion many months into the operation of the scheme: to qualify for payment, a claimant had to have been born in the UK or have had a parent or grandparent born here. This meant that around 1,000 British subjects who had no such close "bloodlink" to the UK were ineligible for compensation.

We found that the actions of the MOD constituted maladministration in four respects: the overly quick manner in which the scheme was devised; the lack of clarity in the announcement of the scheme; the failure to ensure that the introduction of the new criterion did not have an adverse impact in



terms of equal treatment; and the failure to inform claimants that the eligibility criteria had been changed.

The Ombudsman made four recommendations to the MOD. The MOD agreed to apologise to complainants for the distress caused by their maladministration and to consider whether that regret should be expressed tangibly. However, the MOD did not agree to review the operation of the scheme or to consider the position of those denied payment because of the bloodlink criterion. The Ombudsman therefore laid her report before Parliament under section 10(3) of the Parliamentary Commissioner Act 1967, denoting that she had found maladministration that the Government did not intend to remedy.

The Ombudsman made three further recommendations to the Government about the devising and operation of ex gratia schemes generally, concluding that

“Where schemes are the subject of large numbers of complaints alleging maladministration or other criticisms from the courts or in Parliament, I believe that it is good administrative practice to review the relevant scheme.”

The Public Administration Select Committee (PASC) in their own report on the subject said:

“We are disturbed that the MOD refused to conduct a review of the administration of the scheme, even though the Ombudsman provided evidence of inconsistent decision making.”²

When PASC took evidence on the report in December 2005 the MOD Minister told the Committee that evidence of the inconsistencies identified by the Ombudsman had now come to light. The MOD subsequently carried out an internal review which revealed that errors had been made. A ministerial statement to the House of Commons in March 2006 announced proposals to widen the scheme to include those people with 20 years’ residence in the UK. At the time of writing, the bloodlink criterion has been suspended pending the results of judicial appeals with regard to its lawfulness under the Race Relations Act 1976. There is also an ongoing internal inquiry into the MOD’s handling of the scheme which has yet to report.

² House of Commons Public Administration Select Committee, A Debt of Honour, First Report of Session 2005-06, HC 735



The importance of good complaint handling

A number of complaints that we investigate fall into the category of those that should never have got as far as the Ombudsman. This is because they were not handled properly at source. It usually happens that, once we have investigated, the department concerned acknowledges the original mistake, apologises, makes appropriate redress and acts to ensure a similar situation will not recur. However, if the complaint had been dealt with effectively at a local level, these remedies could have been put in place sooner and the complainant would have benefited earlier. The case of Mr F on page 12 bears all the hallmarks of this type of complaint. For this reason, we spend considerable time working with departments to improve their complaint handling processes, which we are convinced is best for complainants.

Inadequate departmental complaint handling

Mr F complained that incorrect information provided by the Immigration and Nationality Enquiry Bureau (INEB) of the Immigration and Nationality Directorate (IND) of the Home Office had caused him and his wife to suffer a financial loss.

On 19 August 2003, Mrs F was granted entry clearance to the UK as a spouse at a British High Commission. The visa was valid for two years and Mrs F entered the UK on 5 September 2003. IND advises that, to qualify for indefinite leave to remain, a spouse must have completed two years in the UK as a holder of a spouse visa.

We found that Mr F had telephoned INEB on several occasions in March 2005 to ask when his wife would be eligible to apply for indefinite leave to remain in the UK. The information he was given was incorrect, since he was not asked for the date when she had entered the UK. Unaware that his wife would in fact be unable to apply until August, Mr F made plans to travel abroad on 29 July. On discovering that the date he had been given was incorrect, Mr F complained to the IND complaints unit. They were unable to confirm what information he had been given because they could not access recordings of his telephone calls owing to technical problems.

Mr F's MP took up his case with the Home Secretary, who suggested that Mrs F should apply for a short

extension to the visa to enable her to travel at the end of July and that Mr F could complain to IND complaints unit. The unit, having finally listened to the telephone calls, rejected Mr F's complaint, saying that he had not given the officer Mrs F's date of arrival in the UK. Meanwhile, Mrs F was granted a short extension to enable her to travel abroad and applied for indefinite leave to remain on her return to the UK. This required a total payment of £835, including a postal fee of £335, which Mr F asked IND to refund. Further letters from the MP to the Home Secretary did not resolve Mr F's complaint.

Following our enquiries, IND agreed that telephone officers are expected to ensure they gather all the relevant information but had not done so in Mr F's case. Furthermore, the officer investigating Mr F's complaint had not considered the issue of effective questioning at all. We considered that had IND done so, Mr F's complaint could have been resolved much sooner and without the Ombudsman's intervention. IND agreed to refund the cost of the postal fee of £335 to Mr and Mrs F. They also apologised for the stress and inconvenience caused and offered a consolatory payment of £50 in recognition of that. They have taken measures to ensure that telephone officers ask appropriate questions in order to give accurate advice to callers.

As we indicated in the Introduction to this section, some of our investigations conclude that the body complained against handled the complaint properly. An example is the case of Mr S on page 13.

Failing to focus on the customer

Many of the complaints that we investigate display classic problems of lack of customer focus. These are often displayed in poor or insufficient information or advice, poor communication with customers, delays in processing cases and inadequate record keeping. The result is stress and anxiety for the customer, often coupled with financial difficulties. Our report on the Government's actions in relation to occupational pension schemes illustrates the major consequences for customers of the provision of misleading information. It is also another example of defensiveness about our findings of maladministration.

Trusting in the pensions promise

Trusting in the pensions promise (HC 984) was published in March 2006. It reported on our investigation into the role of government bodies in relation to the security of final salary occupational pensions. MPs referred more than 200 cases to the Ombudsman, who also received 500 direct representations from members of the public.

Complainants alleged maladministration on the part of the Department for Work and Pensions, the Treasury, the National Insurance Contributions Office of HM Revenue and Customs and the former Occupational Pensions Regulatory Authority. Complainants considered that the Government led members of defined benefit occupational salary schemes to believe that their pensions were safe in the event that the scheme was wound up, when this was not necessarily the case. As a result, complainants believed that they were misled into remaining in their employer's defined benefit scheme and lost the opportunity to move their pension fund elsewhere or to take other action to protect their position. They received a substantially smaller pension than they had been led to expect when their scheme wound up with insufficient assets to meet all its liabilities and the Government's compensation scheme did not cover all their losses.

The Ombudsman launched her investigation in November 2004. It uncovered evidence of real suffering, distress and uncertainty about the future among pension scheme members and their families, who had relied on government information when making choices about their future pension provision. We found that official information provided over many years by government bodies was inaccurate, incomplete, unclear and inconsistent. There was a clear mismatch between the level of security that final salary occupational scheme members could expect from the legal, regulatory and administrative frameworks in place

Good departmental complaint handling

In December 2004, Mr S complained to the Judicial Correspondence Unit (JCU) of the Department for Constitutional Affairs about the conduct of a judge at a financial dispute court hearing. Mr S claimed that the judge stood up and shouted at him and threatened him with punitive costs to pressurise Mr S to abandon some of the arguments he presented at court. JCU wrote to Mr S in February 2005, setting out the limits of their investigation and explaining that there were insufficient grounds to conclude that the judge had acted improperly.

Mr S was dissatisfied and complained again to JCU. JCU contacted the judge and asked him for his comments. Having received

his reply, they again wrote to Mr S explaining that they had no concerns about the judge's conduct. In April 2005, Mr S wrote to JCU saying that he was still dissatisfied and insisting that they listen to the tapes of the hearing. They did so, but felt there was nothing on the tapes to indicate that the judge had acted improperly. Mr S asked JCU to provide him with the tapes, but they advised him that the tapes were the property of HM Courts Service and that he would have to direct his request to them.

Mr S subsequently complained to the Ombudsman about JCU. The Ombudsman is unable to investigate actions taken by judges themselves. These fall outside her jurisdiction. However, our enquiries showed that JCU had appropriately investigated Mr S's complaint. They gathered evidence from Mr S and the judge and listened to the tapes of the hearing, enabling them to verify their findings directly against what happened in court. We did not uphold Mr S's complaint.



and the information that was put into the public domain about such protection. The Ombudsman concluded that, having set the pensions policy framework and taken upon itself the responsibility to provide information to the public, the Government had a unique responsibility in this area.

The report made five recommendations. These included that the Government should consider whether it should make arrangements for the restoration of the core pension and non-core benefits to those categories of scheme members covered by the report. It is very disappointing that the Department for Work and Pensions contests the findings of the report and has rejected the recommendations. Consequently, the report was laid before Parliament under section 10(3) of the Parliamentary Commissioner Act 1967, indicating that injustice has been caused by maladministration that the Government does not intend to remedy. Since publication, the Public Administration Select Committee has taken evidence on the report from the Ombudsman and is planning also to hear from Government Ministers and representatives of complainants. In addition, the Government published its full response to the report on 6 June 2006, which set out the basis for its decisions to reject the Ombudsman's findings and all but one of her recommendations. Those decisions are now the subject of an application for judicial review by the Pensions Action Group.

The Department for Work and Pensions – improving customer focus

As in previous years, the Department for Work and Pensions (DWP) has been one of the major sources of complaints to the Ombudsman (figure 3). The majority of complaints are about the Child Support Agency (CSA) and Jobcentre Plus. We concluded 600 complaints in total, 35% of all parliamentary complaints reported on during the year. We continued to work with the DWP to improve complaints handling and to promote improvements in customer service. This year, the DWP set up a prototype independent tier of complaints handling, which they hope will build and improve on the Independent Case

Examiner model, which already exists for the CSA. We welcome this development and hope that it will enable the DWP to resolve more complaints close to source, which we believe is preferable for complainants.

The DWP and its agencies deal with very large numbers of people and we accept that mistakes will happen from time to time. However, a recurring feature of complaints we receive is poor customer service, especially incorrect information, poor record keeping and the failure to learn from complaints. It is, therefore, especially important that large public service providers such as DWP and all its agencies handle complaints well and have systems and procedures in place for putting things right when they



have gone wrong. The case of Mr and Mrs M (see case study on page 16) demonstrates the impact on customers of mishandling of their case by Jobcentre Plus over a period of years.



Figure 3
Complaints against the Department for Work and Pensions and its agencies 2005-06

	Accepted for investigation in year	Reported on in year	Percentage upheld in full or in part	In hand at 1.4.06
Jobcentre Plus	263	221	52%	147
Child Support Agency	209	180	83%	177
Pension Service	97	111	45%	39
Disability and Carers Service	72	54	44%	38
Department for Work and Pensions*	16	22	45%	24
Debt Management Unit	15	10	80%	12
Rent Service	2	2	50%	1
Total	674	600	60%	438

*Includes the lead complaint about occupational pensions

Persistent mishandling of claims

Mr and Mrs M complained that Jobcentre Plus mishandled their claims to income support, with the result that for six years they had not received benefit to which they were entitled. As a result, they had also lost entitlement to free school meals, help with school uniforms and council tax benefit. They said that financial difficulties had led them to take out loans, left them in debt and had caused them gross inconvenience and severe distress. They also complained that Jobcentre Plus mishandled their complaint about the matter and wrongly refused their claim for a special payment.

We found that when they assessed Mr M's claim for income support in 1999, Jobcentre Plus overlooked his underlying entitlement to carer's allowance and therefore failed to award a carer premium. As a result,

income support was not paid until a new claim was successfully made in 2003. Despite claims from Mrs M, the original mistake was not identified until 2004; and because of a flawed and delayed decision on Mrs M's claim for a special payment, it was not put right until our intervention in 2005.

Jobcentre Plus agreed to pay Mr and Mrs M compensation of more than £18,000, covering arrears of income support, late payment of benefit, lost entitlement to free school meals and to help with school uniforms, and a payment to meet charges on debts. They also agreed to reimburse expenses of £300 and made consolatory payments of £500 for gross inconvenience and £200 for distress. Jobcentre Plus apologised to Mr and Mrs M for their handling of the case.

In our 2004-05 Annual Report, we expressed considerable concern about the operations of the Child Support Agency (CSA). Significant problems over a period of years included delays in processing cases, incorrect assessments, problems with enforcement, poor communication with customers and difficulties with CSA's computer system. These were compounded by changes to the method of calculating child support in 2003 and lack of staff training in new systems. We recognised the challenges faced by the Agency in this complex area of work, particularly in securing payments from non-resident parents. However, we considered that management and system failures needed to be urgently addressed.

In February 2006, the Secretary of State for Work and Pensions announced a fundamental review of child support and a range of interim measures to improve the level of service to customers under the existing arrangements. The issues raised by failings at the CSA will take a considerable time to address. The complaints we received about CSA's operations included cases going back over several years. For example, the case of Mr M on page 17 illustrates the kind of problems customers continue to experience.





Case Study
Ref. PA-1205

Mistakes in processing claims and delays caused by computer problems

Mr M complained that the Child Support Agency had mishandled his case. They had delayed issuing a maintenance enquiry form in 2004 to the non-resident parent, Mrs Y, thus delaying the effective date when she became liable to pay child support. They had also wrongly cancelled a deduction from earnings order imposed on Mrs Y. As a result, Mr M had failed to receive maintenance as it fell due.

We criticised the Agency for the delay in issuing the maintenance enquiry form to Mrs Y. However, we welcomed the fact that they had since compensated Mr M for the lost opportunity to receive maintenance. That payment made up for the fact that they had taken no action over Mr M's appeal against the effective date of Mrs Y's liability.

We also noted that all progress on the case came to a halt when the Agency encountered difficulties with the new CS2 computer system. This meant that they had to take the case off the system to process it clerically. This also led to them cancelling the deduction from earnings order, even though it could have remained in place when it was decided that payment should be made manually. Mr M therefore had to wait several months to receive a payment made by Mrs Y to the Agency.

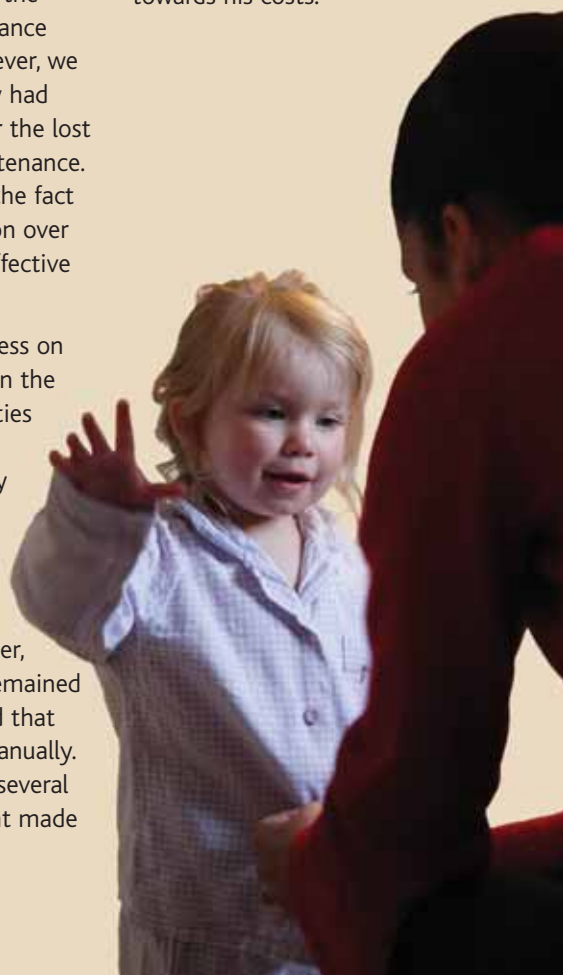
Since Mrs Y now owed arrears of maintenance which would take several months to recover through deduction from earnings, the Agency agreed to pay Mr M an advance payment plus interest. They recognised that he would already have received the arrears if they had not mistakenly lifted the earlier deduction from earnings order. They also agreed to award Mr M a consolatory payment of £50 and £5 towards his costs.

Putting things right

Redress is an essential element of complaints resolution. Where we find that things have gone wrong, our focus is on putting the complainant back in the position they would have been in before the mistake occurred. In some cases, this might mean an apology and an appropriate change in a decision about a complaint; in others, it might involve financial compensation and/or consolatory payments for the distress and inconvenience caused.

We also aim to ensure that departments and agencies make general improvements to their services where a complaint or a series of complaints reveal recurring problems. As the Ombudsman noted in *A Debt of Honour*,

"An early recognition that lessons can be learned from complaints and other feedback can prevent systemic failure or a situation in which public resources are expended on remedial action, which would not have been necessary had a thorough review taken place at the appropriate time and had any corrective action been carried out proactively."





Complainants often express the wish that similar problems could be avoided in the future. Some departments have indicated that they have learned from mistakes and found our intervention helpful in developing their services. For example, following our investigation of a complaint by Mr C (PA-5795), Ofcom commented,

“Your investigation ... has proved a useful and timely exercise in assessing our current procedures with reference to our consultation on our guidelines for the handling of fairness and privacy complaints.”

Tax credits – putting things right

In last year's *Annual Report*, we summarised the findings of our special report published in June 2005, *Tax credits: putting things right* (HC 124). We had received a large number of complaints about the operation of the Child and Working Tax Credits system. These mainly concerned the way the Revenue handled the recovery of overpayments, the impact of which was felt hardest by poor families with children and people on low incomes – new groups of customers for the Revenue. The Revenue had previously given assurances that the difficulties were teething-problems, but it became clear that improvements to the system were needed. The Public Administration Select Committee took a particular interest in the subject and published their own report.³

We have had constructive discussions with the Revenue about improvements to the tax credit system and they have taken significant steps towards improving it. These include overhauling the way they handle complaints, exploring ways of delaying the recovery of overpayments and postponing the transfer of customers currently receiving support for their children through income support or job seekers allowance from the Department for Work and Pensions rather than tax credits and we welcome the progress that has been made. We recognise that the problems cannot be resolved overnight. We will therefore continue to monitor how the Revenue handles the delivery of the tax credit system and the complaints we receive about the service they provide, to determine if a second special report is needed.

The number of complaints we received relating to tax credits had considerable repercussions for our own workload this year. We had 204 cases in hand on 1 April 2005 and accepted 404 for investigation during the year – around 22% of our overall Parliamentary workload. We concluded 299 cases during the year, which were mainly about overpayments and their recovery (see case study on page 19). Of these, we fully or partly upheld 90% – a high level of complaints upheld in relation to other parliamentary complaints. This volume resulted in significant delays in cases being investigated and resolved.

Many of these complaints should have been handled by the Tax Credit Office, but delays in responding led to them being referred to us. We are now satisfied that the Revenue's complaints handling processes have improved.



Overpayment of tax credits

Mr and Mrs B claimed tax credits in December 2002 and the Revenue awarded them child tax credit only in March 2003. In May 2003, Mrs B stopped work and started to claim contribution-based jobseeker's allowance. This does not carry with it any automatic entitlement to the maximum amount of child tax credit and working tax credit, whereas entitlement to income-based jobseeker's allowance does. Mrs B telephoned the tax credit helpline in May 2003, telling them that the income details held on their records were incorrect and that she had started claiming jobseeker's allowance. She did not specify which type of jobseeker's allowance it was and the adviser did not ask. The Revenue sent two revised award notices in May 2003 for working tax credit and child tax credit. These said that Mr and Mrs B's award had been revised and included the information that Mrs B was in receipt of

jobseeker's allowance (income-based). Mrs B telephoned the helpline to query the award and was told it was correct.

In April 2004, the Revenue wrote to Mr B to say he had been overpaid tax credits of nearly £1,200; in subsequent correspondence, the figure increased significantly to almost £7,500. The Revenue said they would recover it either by reducing his future tax credit payments or, if he were no longer receiving tax credits, by asking him to repay the full amount. Despite representations by the local Citizens' Advice Bureau and their MP, the Revenue told Mr and Mrs B in November 2004 that they had reconsidered the overpayment, but still concluded that it was recoverable. They thought it reasonable to expect Mrs B to have noticed that the award notice incorrectly said she was in receipt of income-based jobseeker's allowance.

Our investigation found that Mr and Mrs B could not be expected to appreciate the difference between different types of jobseeker's allowance or the likely impact of that on their tax credit claim. When Mrs B telephoned the helpline to query the award, the adviser did not point out the difference between the two types of allowance and instead confirmed that the award was correct. It was therefore reasonable for Mrs B not to query the award further. Following our intervention, the Revenue decided to remit the overpayment in full and to pay back to Mr and Mrs B any money already recovered. They have also agreed to award Mr and Mrs B a consolatory payment of £50 for inconvenience, £10 for direct costs incurred in pursuing the complaint and £25 for the Revenue's delay in resolving the complaint. They also apologised to Mr and Mrs B.

From 1 April 2006, therefore, our policy is to investigate only those complaints that have exhausted the Revenue's complaints procedure, those which raise new issues that need exploring or cases where other issues make it inappropriate to refer them

back to the Revenue. We are confident that this approach will result in a better service to complainants.

³ House of Commons Public Administration Select Committee, Tax Credits: Putting Things Right, Second Report of Session 2005-06, HC 577

Improving services for people with a disability

Mr A is profoundly deaf and communicates using British Sign Language (BSL). Sign It! (an organisation that supports BSL users) complained on behalf of Mr A that the Disability and Carers Service (DCS) of the DWP refused Mr A's renewal claim for disability living allowance in 1999, when he reached the age of 16, and a new claim in 2001. As a result, Mr A did not receive disability living allowance for the period between 1999 and 2003, when Sign It! became involved. In common with many profoundly deaf people who use BSL, Mr A has difficulty reading. The decisions and information about his appeal rights were sent to him in letters he was unable to read and understand and he did not appeal at the time of the decisions.

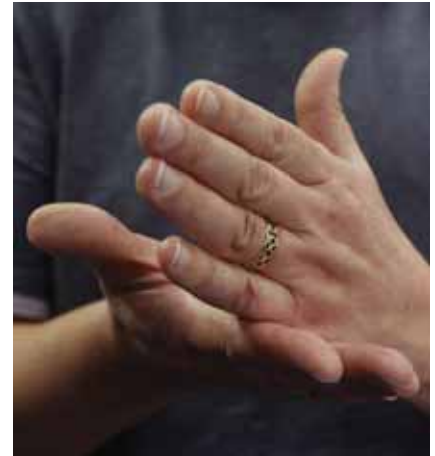
When we investigated the case, we passed on details of Mr A's circumstances between 1999 and 2003 to the DCS. They agreed that the 1999 and 2001 decisions were incorrect due to official error, since the adjudication officer did not fully take into account the fact that Mr A was still in full time education and used BSL as a first language. The DCS have now paid Mr A around £9,500 for the disability living allowance he should have received between 1999 and 2003 and interest on this money. They also made a consolatory payment of £250 for the inconvenience caused.

The investigation revealed problems with how the DCS handle claims from people who are profoundly

deaf. Although there were procedures in place to help people like Mr A, the system was not working well. We therefore hosted a meeting between Sign It! and the DCS to discuss the steps the DCS could take to improve the service. The DCS agreed to look into several additional cases to try to resolve the problems and identify where things went wrong. They are also taking steps to improve the consistency and quality of decision making; to target people with hearing impairments to increase accessibility and raise awareness of disability living allowance; and to make improvements to their IT system to increase understanding among staff of communication issues and various conditions, including hearing impairment.

"The hard work you have put in collecting and collating essential evidence has been instrumental in bringing about what I feel will be a landmark change in the way our duty of care towards the disabled in our society is discharged."

(Mr E of Sign It!).



Wide reaching benefits for others

Two further cases show how a single complaint can lead to the alteration of policy or practice, thus potentially benefiting other customers.

Improving accessibility to services

Mrs D, who lived in Spain, made her complaint to us in Spanish, her first language, and we arranged to have her letters translated. She complained that The Pension Service (TPS) continued to pay her English state pension by means of payable orders which she could not use, and that she had told them this on several occasions.

Our investigation found that Mrs D had not had the benefit of her pension since 2002, because she had not cashed the payable orders that TPS had sent her. It was not clear why she had not cashed them but she had been writing to TPS about the matter throughout 2003. TPS wrote to her twice, in English, explaining that, if it would be easier for her, she could ask to have her payment made directly into a Spanish bank account or they could send cheques to a post office address. They asked her to let them know her wishes. TPS said that, because the cheques were not cashed and because Mrs D did not sign and return to them certain documents, in August 2005 they stopped her pension.

TPS realised that they had not replied to all Mrs D's letters and that they should have considered writing to her in Spanish. As a result of the Ombudsman's intervention, they agreed to reinstate her pension, pay her all the arrears which had accrued

since 2002 and to apologise to her. They wrote to Mrs D in Spanish and, recognising that she might find it difficult to deal with them in writing, they arranged for the British Consulate in Malaga to contact her in person. The Consulate invited Mrs D for an interview but she did not attend and so they arranged to visit her.

The Ombudsman upheld Mrs D's complaint about the failure to reply to her letters. If TPS had considered sooner how best to overcome the communication difficulties, Mrs D might not have needed to make her complaint and she might not have been without the use of her pension for so long. The Ombudsman was satisfied that the steps The Pension Service took following her intervention was a suitable way to put things right.

The Ombudsman did not uphold Mrs D's complaint that TPS continued to send her cheques she could not use as they had offered Mrs D alternative methods of payment but she had not responded.

Providing a seamless service

Organisational boundaries between service providers often create difficulties for complainants: first, in receiving a joined-up and customer-focused service; and secondly, in making a complaint when services do not meet expectations. Current legislation also places restrictions on joint working between public sector Ombudsmen where a complaint crosses jurisdictions. Despite this, the Parliamentary Ombudsman has worked effectively in parallel with the Local Government Ombudsmen on a number of occasions, notably on the landmark case of Mr and Mrs Balchin (see case study on page 22). This clearly showed the need to reform the legislative framework governing working arrangements between Ombudsmen to allow them to publish joint reports and share information. The Cabinet Office has consulted on a proposed Regulatory Reform Order, which would achieve this and enable us to provide a better service to complainants in the future.

Redress in the round – joining up to put things right

Mr and Mrs Balchin's complaint about the actions of the Department for Transport and Norfolk County Council was a very long-running saga, starting in 1986. The Council refused to buy the Balchins' home in advance of an intended road bypass scheme, which was later dropped. Mr and Mrs Balchin experienced extreme financial difficulties because of the impact of the proposed bypass on the value of their property and on Mr Balchin's business, for which he had used their home as security to raise working capital. In June 1996, the Council decided to rescind the bypass scheme. Mr and Mrs Balchin were subsequently able to sell their property, but its value was only sufficient to pay off the debts that had accrued in the meantime. As a result, Mr and Mrs Balchin suffered from stress, anxiety and ill health.

One of the Local Government Ombudsmen, Jerry White, investigated the actions of the Council, concluding that it could not reasonably have refused to buy the property if the matter had been properly considered. The Parliamentary Ombudsman, investigating the Department's actions, said that it should have given clearer guidance to the Council about their power to purchase properties that would be badly affected, but not technically blighted, by the proposed new road.

The Ombudsmen concluded that each body must carry an equal share of the responsibility for the hardship caused to the Balchins and should each pay them £100,000. Both the County Council and the Department for Transport agreed to the recommended compensation.

The legislation covering the Ombudsmen's remit requires each of them to publish a separate report. Both reports are complete in themselves, but the full story can only be understood if they are read together. For that reason, each report has the other annexed to it.



Other issues under investigation

Prudential regulation of the Equitable Life Assurance Society

The Ombudsman is conducting an investigation into the prudential regulation of the Equitable Life Assurance Company in the period before 1 December 2001. The terms of reference are:

To determine whether individuals were caused an injustice through maladministration in the period prior to December 2001 on the part of the public bodies responsible for the prudential regulation of the Equitable Life Assurance Company and/or the Government Actuary's Department; and to recommend appropriate redress for any injustice so caused.



This is a complex and extensive investigation covering 18 specific heads of complaint and using 15 representative complainants as lead cases. Producing an authoritative and robust report into a complex regulatory regime and its operation, covering many technical matters, will take a considerable time. The Ombudsman has kept Members of Parliament and complainants informed of progress.

In January this year, in response to a petition by Equitable Life policyholders and annuitants, a European Parliament Committee of Inquiry was set up to consider whether the relevant EU legislation had been properly applied in the UK.

The Committee is investigating the way in which the UK authorities applied the relevant Council directives, examining whether the European Commission properly monitored the

transposition of Community law and assessing allegations that UK regulators consistently failed to protect policy holders by rigorous supervision of accounting and provisioning practices and of the financial situation of Equitable Life.

The Committee has twelve months to complete its inquiry and report to the European Parliament and has already produced an interim report.

Figure 4
Parliamentary complaints by body complained about

Body	Accepted for investigation in year	Reported on in year	Percentage upheld in full or in part	In hand at 1.4.06
Appeals Service	20	16	13%	13
Arts Council of England	1	1	0%	0
Asylum and Immigration Tribunal	3	2	50%	1
Cabinet Office	1	1	0%	0
Charity Commission	5	9	33%	3
Child Benefit Centre	0	1	0%	0
Child Support Agency	209	180	83%	177
Children and Family Court Advisory and Support Service	25	30	30%	7
Civil Aviation Authority	4	4	25%	0
Coal Authority	2	1	0%	1
Commission for Patient and Public Involvement in Health	6	6	0%	0
Commission for Racial Equality	3	3	33%	0
Commission for Social Care Inspection	23	24	58%	14
Companies House	1	1	0%	0
Construction Industry Training Board	1	1	0%	0
Consumer Council for Postal Services	0	1	0%	0
Consumer Council for Water	1	1	0%	0
Countryside Agency	3	2	50%	1
Criminal Injuries Compensation Appeals Panel	2	1	0%	2
Criminal Injuries Compensation Authority	11	8	38%	6
Criminal Records Bureau	19	11	55%	16
Debt Management Unit	15	10	80%	12
Department for Constitutional Affairs	15	10	20%	8

Figure 4

Parliamentary complaints by body complained about (continued)

Body	Accepted for investigation in year	Reported on in year	Percentage upheld in full or in part	In hand at 1.4.06
Department for Culture, Media and Sport	1	1	0%	0
Department for Education and Skills	15	8	0%	5
Department for Environment, Food and Rural Affairs	16	24	21%	12
Department for International Development	1	1	0%	0
Department for Transport	5	6	33%	1
Department for Work and Pensions	16	22	45%	24
Department of Health	4	6	17%	4
Department of Trade and Industry	14	13	38%	8
Disability and Carers Service	72	54	44%	38
Driver & Vehicle Licensing Agency	28	24	21%	5
Driving Standards Agency	8	9	56%	0
Employment Appeal Tribunal	2	1	0%	1
Employment Tribunals Service	8	12	25%	1
English Nature	1	1	100%	0
English Partnerships	1	2	0%	0
English Sports Council	1	1	100%	2
Environment Agency	9	12	33%	6
Equal Opportunities Commission	1	1	0%	0
Foreign and Commonwealth Office	20	11	36%	14
Forestry Commission	1	1	0%	0
Gas and Electricity Consumer Council	2	3	0%	0
Government Office for the North East	1	1	0%	0
Government Office for the North West	1	1	0%	0
Government Office for the South West	1	1	0%	0
Government Offices	4	4	0%	1
Health and Safety Executive	8	8	38%	3
Healthcare Commission	4	1	100%	4
Highways Agency	9	14	29%	6
HM Courts Service	53	69	54%	23
HM Prison Service	4	5	60%	1
HM Revenue and Customs – tax credits	404	299	90%	309
HM Revenue and Customs – other	144	114	30%	101
HM Treasury	1	2	0%	12
Home Office	9	15	47%	9
Horticultural Development Council	0	1	0%	0
Housing Corporation	1	1	0%	0
Immigration and Nationality Directorate	95	75	88%	54
Immigration Appellate Authority	0	1	0%	0
Information Commissioner	12	13	8%	4
Insolvency Service	7	7	0%	5
Jobcentre Plus	263	221	52%	147
Land Registry	17	17	12%	3
Learning and Skills Council for England	3	2	50%	1



Figure 4

Parliamentary complaints by body complained about (continued)

Body	Accepted for investigation in year	Reported on in year	Percentage upheld in full or in part	In hand at 1.4.06
Legal Services Commission	55	54	44%	30
Marine Consents and Environment Unit	1	1	0%	0
Maritime and Coastguard Agency	0	1	0%	0
Medical Research Council	0	1	100%	0
Ministry of Defence	3	3	33%	1
National Insurance Contributions Office	14	14	79%	6
NHS Pensions Agency	1	1	0%	0
Northern Ireland Court Service	2	1	0%	1
Northern Ireland Office	1	1	100%	0
Occupational Pensions Regulatory Authority	0	2	100%	0
Office for National Statistics	2	2	50%	0
Office for Standards in Education (OFSTED)	2	1	100%	2
Office of Communications	2	3	33%	0
Office of Fair Trading	1	2	0%	0
Office of Her Majesty's Chief Inspector of Schools in England	0	2	100%	0
Office of the Deputy Prime Minister	7	8	0%	2
Office of the Director General of Water Services	5	6	0%	1
Office of the Immigration Services Commissioner	3	2	0%	2
Official Solicitor	1	2	0%	0
Ordnance Survey	0	1	0%	0
Parole Board	2	1	0%	1
Pension Service	97	111	45%	39
Pensions Ombudsman	8	9	44%	2
Planning Inspectorate	37	34	6%	5
Postwatch	1	2	50%	1
Prisons and Probation Ombudsman	3	4	0%	1
Public Guardianship Office	11	5	60%	11
Rent Service	2	2	50%	1
Residential Property Tribunal Service	4	3	0%	1
Rural Payments Agency	12	10	20%	9
Security Industry Authority	0	1	100%	0
Special Educational Needs & Disability Tribunal	2	1	0%	1
Standards Board for England	8	3	0%	5
State Veterinary Service	1	1	0%	0
Treasury Solicitor's Department	1	2	0%	0
UK Passport Service	7	7	0%	2
UK Patent Office	1	1	0%	0
UK Visas	5	2	50%	5
Valuation Office Agency	15	7	29%	10
Vehicle and Operator Service Agency	2	1	100%	1
Veterans Agency	8	9	44%	6
Grand Total	1,964	1,734	54%	1,211



“NHS funding for long-term (or continuing) care is a long-standing concern and has continued to be a major, but now declining, part of our work this year.”

The NHS: making things better for patients

In 2005-06, we reported on 1,891 health cases (including 1,097 which related to continuing care) and a further 12 were discontinued at the request of the complainant.

Figure 5
Health cases accepted and concluded in 2005-06

	In hand at 1.4.05	Cases accepted for investigation in year	Cases reported on in year	Discontinued cases	In hand at 1.4.06
Health – continuing care	744	553	1,097	3	197
Health – other	564	756	794	9	517
Health – total	1,308	1,309	1,891	12	714

These cases fell within areas covered by the strategic health authorities as shown in the table on pages 28 and 29.



Figure 6
Distribution of health cases by Strategic Health Authority area 2005-06

Strategic Health Authority area	Continuing care						Other				
	In hand at 1.4.05	Accepted for investigation in year	Discontinued in year	Reported on in year	In hand at 1.4.06	In hand at 1.4.05	Accepted for investigation in year	Discontinued in year	Reported on in year	In hand at 1.4.06	
Avon, Gloucestershire and Wiltshire	32	33	0	45	20	10	17	1	13	13	
Bedfordshire and Hertfordshire	11	12	0	21	2	11	11	1	12	9	
Birmingham and The Black Country	25	12	0	36	1	23	21	1	24	19	
Cheshire and Merseyside	104	70	0	160	14	25	33	0	30	28	
County Durham and Tees Valley	9	8	0	17	0	12	9	0	13	8	
Cumbria and Lancashire	46	23	0	62	7	21	24	0	31	14	
Dorset and Somerset	50	42	1	81	10	10	10	0	13	7	
Essex	29	26	0	49	6	13	22	0	17	18	
Greater Manchester	39	35	0	58	16	45	27	0	54	18	
Hampshire and Isle of Wight	6	23	0	21	8	12	7	0	11	8	
Kent and Medway	12	14	0	22	4	23	20	0	28	15	
Leicestershire Northamptonshire and Rutland	19	17	0	25	11	14	11	1	12	12	
Norfolk Suffolk and Cambridgeshire	2	18	0	17	3	21	16	0	21	16	
North and East Yorkshire and Northern Lincolnshire	16	10	0	21	5	16	11	0	19	8	
North Central London Strategic Health Authority	17	9	0	22	4	26	26	0	25	27	
North East London	28	10	0	36	2	29	36	1	39	25	
North West London	3	10	0	8	5	34	28	1	34	27	



Figure 6
Distribution of health cases by Strategic Health Authority area 2005-06 (continued)

Strategic Health Authority area	Continuing care					Other				
	In hand at 1.4.05	Accepted for investigation in year	Discontinued in year	Reported on in year	In hand at 1.4.06	In hand at 1.4.05	Accepted for investigation in year	Discontinued in year	Reported on in year	In hand at 1.4.06
Northumberland, Tyne and Wear	15	12	0	20	7	15	13	0	20	8
Shropshire and Staffordshire	28	10	0	26	12	10	12	0	10	12
South East London	17	10	0	22	5	27	16	0	32	11
South West London	14	15	0	25	4	17	12	0	14	15
South West Peninsula	50	28	1	68	9	20	14	1	21	12
South Yorkshire	19	11	0	28	2	11	2	1	11	1
Surrey and Sussex	29	28	0	51	6	33	27	1	34	25
Thames Valley	16	24	0	29	11	18	22	0	17	23
Trent	51	26	1	58	18	15	32	0	27	20
West Midlands South	32	9	0	37	4	15	19	0	19	15
West Yorkshire	25	7	0	31	1	24	22	0	24	22
Healthcare Commission	0	1	0	1	0	13	233	0	168	78
Other*	0	0	0	0	0	1	3	0	1	3
Total	744	553	3	1,097	197	564	756	9	794	517

*Includes Prescription Pricing Service, National Clinical Assessment Service, and the Rampton Hospital Authority



A single case brought to us by a complainant may include complaints about more than one body – for example, a complainant might complain about the actions of a GP and a hospital or primary care trust. It is therefore important that, as well as recording the number of cases we report on, we also record the number of bodies complained about.

The following table shows the health complaints we reported on during the year by type of NHS body.

In future, almost all of the cases we receive will have been reviewed by the Healthcare Commission, which is responsible for administering the second stage of the NHS complaints procedure. Such cases will normally be referred to us where the complainant is unhappy with the Healthcare Commission's process, decision or service, and these cases will be recorded as complaints against the Healthcare Commission, with a record of the original body complained about as an interested party.

Although continuing care complaints accounted for more than half of the NHS complaints we reported on in 2005-06, the other complaints we received ranged across 475 different bodies. Most complaints cover several issues and are usually complex and involved. The case of Mr J on page 31 clearly illustrates the number of issues that a single case might reveal. However, there are some recurring themes among complaints. They include complaint handling, communication with patients and their relatives and carers, care planning and record keeping. In all too many cases, the complaints we investigate highlight a lack of patient focus and failures in management and leadership.

Figure 7

Health complaints (excluding continuing care) by type of body 2005-06

Type	Accepted in 2005-06	Reported on in year	Percentage upheld in full or in part	In hand at 1.4.06
Ambulance Trusts	3	6	67%	3
Foundation Trusts	32	35	51%	30
Healthcare Commission	233	167	66%	78
Mental Health, Social Care and Learning Disability Trusts	83	75	65%	64
NHS Hospital, Specialist and Teaching Trusts (Acute)	255	309	61%	178
Primary Care Trusts	99	146	40%	54
Strategic Health Authorities	2	5	100%	0
Dentists	2	18	50%	0
GPs	59	139	42%	2
Opticians	0	1	0%	0
Prescription Pricing Authority	0	1	100%	0
Rampton Hospital Authority	0	1	100%	0
The National Clinical Assessment Service	0	1	0%	0
Total	768	904	56%	409

There were 475 different bodies complained about in 2005-06.

Figure 8

Continuing care complaints by type of body 2005-06

Type	Accepted in 2005-06	Reported on in year	Percentage upheld in full or in part	In hand at 1.4.06
Primary Care Trusts	505	962	92%	169
Strategic Health Authorities	150	362	91%	49
Mental Health, Social Care and Learning Disability Trusts	1	2	100%	0
Healthcare Commission	1	1	0%	0
Total	657	1,327	92%	218

There were 243 different bodies complained about in 2005-06.

Multiple issues involved in a complaint – managing an MRSA positive patient

In January 2003, Mr J, aged 77, was admitted to the Trust with worsening breathlessness. He was diagnosed with a right pneumothorax and possible chest infection. Re-inflating the collapsed lung with a chest drain was unsuccessful and Mr J was transferred to another hospital for surgery. However, he was considered unfit for surgery and was transferred back to the Trust. The transfer notes showed that the site of his chest drain was positive for Methicillin Resistant Staphylococcus Aureus (MRSA). The nursing notes indicated the MRSA positive status of the wound site, but this was not noted in the medical notes until a week after Mr J's transfer back from the second hospital. His condition deteriorated despite a change from amoxicillin to triple antibiotics and he died on 20 February.

Mr J junior complained to the Trust in July 2003 about the medical care and treatment his father received. Dissatisfied with the Trust's reply in September, he requested an independent review (IR). The Convener obtained medical and nursing advice and refused the IR in February 2004, referring the complaint back for local resolution. A meeting was held about the complaint and a note of it sent to Mr J junior. Still dissatisfied, he again requested an independent review, which was again refused in May 2004, following which he complained to the Ombudsman.

The Ombudsman, advised by an experienced geriatrician and an experienced Infection Control Nurse, investigated the following matters:

- A failure to follow systems for managing an MRSA positive patient: there was a failure to follow MRSA policy, but the Trust had only acknowledged part of this failure. We were concerned by the disparity between the action the Director of Nursing believed was taken and that which staff indicated actually occurred. We were also concerned about lack of awareness of training among staff. This complaint was upheld.

We noted with concern Mr J junior's evidence that he was not informed at any time about his father's MRSA status. Given the extent of public concern about MRSA and the seriousness of Mr J's condition, we were critical of Trust staff for not explaining the implications of the MRSA infection.

- Inadequate nursing care, including poor MRSA management and unsatisfactory use of care planning: there was poor nurse evaluation and the use of the correct dressing for MRSA was purely by chance. Nursing documentation was poor, but no changes appeared to have been made, although changes had been made to the care planning system. This complaint was upheld in part.
- Lack of investigation for causative agents of infection: while tests were ordered, they were not

always noted in the medical records. There was also a failure to carry out a blood culture or drain fluid. This complaint was upheld.

- Poor communication with staff at the second hospital and inadequate systems for inter-hospital transfer: we were concerned that the same admission form was used for both of Mr J's admissions to the Trust. There was also a lack of communication with the second hospital and the system for inter-hospital transfer was poor. We upheld this complaint, but welcomed the changes proposed by the Trust.
- Poor complaint handling at local resolution stage: the Trust's initial response to Mr J junior was inadequate, but although there were delays, Mr J junior was kept informed. This complaint was upheld in part.

Our recommendations to the trust involved: carrying out trust-wide audits of clinical records and instituting training; reviewing systems and documentation for inter-hospital transfers; discussing with neighbouring trusts the transfer of information about hospital-acquired infections; reviewing the efficacy of its MRSA policy; and including guidance about communication with patients and carers in the MRSA policy. We made no recommendation about the complaints procedure: the Trust has revised it and its system for monitoring complaints has already demonstrated an improvement.

Complaints handling and the NHS complaints procedure

In last year's Annual Report, we summarised the findings of our special report on the NHS complaints system, published in March 2005, *Making things better? – a report on reform of the NHS complaints procedure* (HC 413). It outlined our concerns about the problems caused by the fragmentation of complaints systems between the NHS, private healthcare and social care; a tendency to focus on process rather than on outcomes for patients; poor leadership and lack of capacity and competence in complaints handling; and an absence of redress for justified complaints. All this added up to a system which made it difficult for people to get a satisfactory response where things had gone wrong.

Since we published the report, we have worked with the Department of Health and the Healthcare Commission to establish a shared understanding of how to achieve improvement. A number of welcome developments have resulted from the Department's commitment to this. First, in our report, we urged leadership from the Department of Health in setting standards of complaint handling to be met by all NHS providers. The Department agreed to this recommendation and we have developed a draft standard for complaint handling with the Department and the Healthcare Commission. It is based on the principles of meeting the diverse needs of actual and potential complainants;

being simple and clear to the complainant; helping to achieve successful outcomes; and demonstrating that positive action has been taken as a result of complaints.

Secondly, we suggested the Department of Health should ensure the adoption of a common approach to complaints handling across health and social care. We therefore welcome the Department's commitment in its White Paper *Our health, our care, our say: a new direction for community services* (Cm 6737, January 2006) to

“develop by 2009 a comprehensive single complaints system across health and social care”.

We are committed to working with the Department, NHS bodies and social care providers, complainants and other complaint handling bodies to ensure the success of an integrated complaints system.

In this connection, we have seen a number of examples this year where the existing arrangements make it difficult for people to know where to turn if they have a complaint. This is particularly the case for people who are resident in nursing homes, where care is provided directly by the nursing home and also by the NHS. Complaints about the nursing home's care that are not satisfactorily resolved at source are referred to the Commission for Social Care Inspection (CSCI), while those about NHS care are handled differently through the NHS complaints system. The evidence shows that complainants find the differences between the two systems perplexing and impenetrable. It may even discourage some people from complaining.





Working nationally and locally – continuing care

NHS funding for long-term (or continuing) care is a long-standing concern and has continued to be a major, but now declining, part of our work this year. Continuing care funding is available for people who have long-term care needs because of accident, illness or disability. The NHS provides the funding, which covers services from the NHS, local authorities and private providers.

Our report, *NHS funding for the long-term care of elderly and disabled people* (HC 399, February 2003), revealed widespread problems in the application of eligibility criteria for deciding who should receive NHS funded care. As a result, some disabled, frail and elderly people had wrongly been denied funding for their care. This had caused unnecessary distress and considerable financial hardship. Following the publication of that report, we received around 4,000 complaints and enquiries about continuing care.

These complaints revealed evidence of significant ongoing problems, including delays in carrying out retrospective reviews of funding decisions. We therefore published a further report in December 2004, *NHS funding for long-term care: follow-up report* (HC 144). The report called on the Department of Health to establish clear, national, minimum eligibility criteria; improve assessment tools; and support training and development. We therefore welcomed the subsequent announcement by the then

Thirdly, the principle of financial redress has never been as widely accepted in the NHS as it has by government departments and agencies. Indeed, where we have recommended it following an investigation, there has sometimes been strong opposition from the NHS body concerned. We have argued for some time that it is an essential part of good complaints handling to put a complainant back in the position they would have been in if the failing had not occurred. The NHS Redress Bill, which has now had its second reading, provides the opportunity to take this principle forward in the NHS. We welcome the Bill's stated intention to reform the way lower value negligence cases are handled in the NHS to provide redress including investigations, explanations, apologies and financial redress where appropriate without the need for the complainant to go to court.

These developments are a welcome step towards a more responsive and patient-focused complaints system. However, there is still a long way to go before it becomes a reality. The quality of complaints handling by local NHS bodies is still very variable and is often dogged by defensiveness and a lack of corporate commitment to taking complaints seriously. Furthermore, the demand for independent review - the second stage of the NHS complaints system, which passed to the Healthcare Commission in July 2004 - proved much higher than forecast. This caused a significant backlog of complaints at the Healthcare Commission, which they have found difficult to address. We have liaised closely with the Healthcare Commission at both strategic and operational levels to support them where we can in the achievement of their recovery plan. We continue to monitor the situation closely, not least because it has significant implications for the workload of our Office.



Parliamentary Under Secretary of State for Community, Dr Stephen Ladyman, that he had commissioned a

“new national framework for the assessment of fully funded continuing care”.

We are pleased that the Department is consulting on a National Framework for Continuing Care Funding. We hope that, in addition to establishing national eligibility criteria for continuing care funding, the framework will clarify the unclear distinction between eligibility for NHS funded nursing care and for fully funded continuing care. We have drawn attention to this lack of clarity on a number of occasions. It was also criticised by Mr Justice Charles in his judgment on the case of Maureen Grogan (R (Grogan) v Bexley NHS Care Trust) in January 2006.

We have worked closely with the Department and with Strategic Health Authorities (SHAs) to support them in the resolution of the large number of continuing care complaints that were still outstanding. To assist with this, we visited every SHA during 2005 to explain our concerns and share recognised good practice in carrying out review processes and reaching decisions. We also drew up and published on our website a guide to what the Ombudsman can and cannot do in relation to complaints about continuing care funding. This included



two checklists against which we assess every complaint about a refusal to agree continuing care funding retrospectively and provide restitution.

The checklists look respectively at whether the process of assessment of a claim was carried out properly; and whether the rationale for a decision not to pay continuing care funding was fair, clear and evidence-based. Where the checklists show that the decision making process or the rationale for the decision was flawed, we recommend that the SHA should ensure that a reassessment or re-review is carried out by the appropriate body.

The Department of Health sent the checklists to all SHAs on 1 December 2005, indicating that compliance with their existing advice would ensure PCTs met the Ombudsman’s checklists. The checklists were also discussed

at a workshop held jointly with the Department of Health on 15 December 2005. We understand that SHAs and PCTs have found the checklists helpful in clarifying how to assess need and run a fair process. We hope this will assist them to deal with the remaining cases properly and fairly.

During the year, we reported on 1,097 cases about continuing care funding. The majority covered flaws in the process for assessing eligibility for funding, such as poorly presented or missing material and review panels not properly constituted (see case study on page 35), and the use of overly restrictive criteria to identify needs. Overall, including complaints investigated using the checklist approach and those investigated by other means, we fully or partly upheld 92% of continuing care complaints. The proportion of continuing care complaints

we upheld is higher than that for other health and parliamentary complaints (56% and 54% respectively).

Where a justified complaint has been upheld and a decision to pay fully funded continuing care has subsequently been made, it has usually made a significant difference to the lives of claimants and their families. Sadly, in some cases the award has come too late to benefit the claimant. Mr M wrote to us in relation to his mother's case (HS-1948):

"I finally heard from our local PCT in January and they agreed to fully fund my mother from the date of her original assessment by Social Services in November 2003. Unfortunately as you know my mother died in October 2004 so the award comes posthumously. However I think it is an important victory for common sense and I am indebted to your efforts and all the others involved in bringing this case to a successful conclusion."

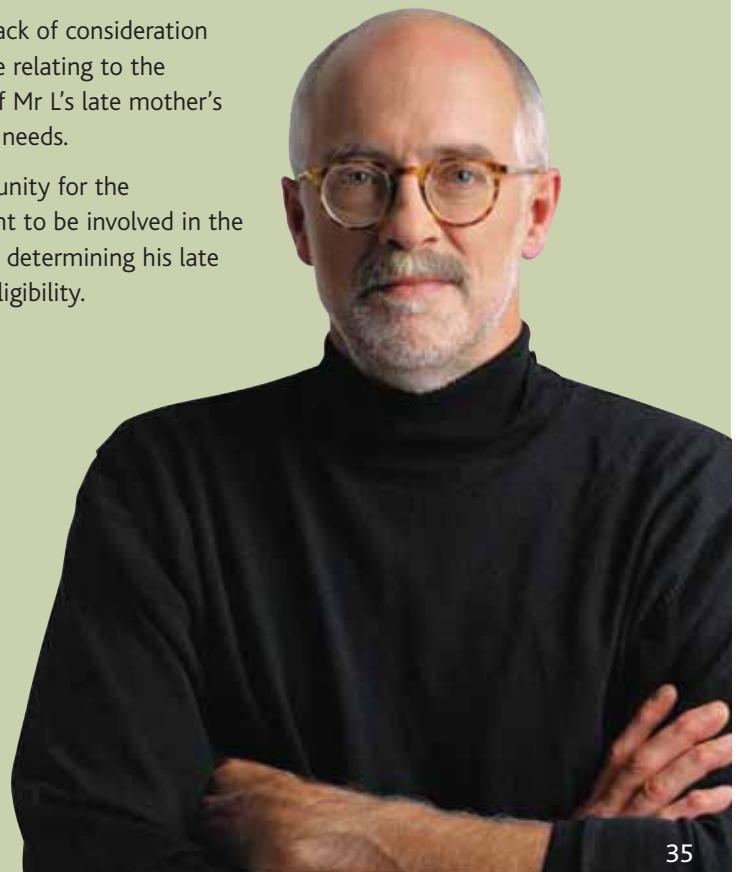
Refusal to fund continuing care

Mr L complained to the Ombudsman that his late mother was refused funding for her continuing care by the PCT, whose decision was upheld by the SHA's Review Panel. Mr L also complained that he had been unable to present his case at any of the panel proceedings.

We found that the process which led to the decision to refuse continuing care funding was unreasonable. The consideration for eligibility of Mr L's late mother was flawed in the following respects:

- Failure to assemble sufficient contemporaneous clinical and social care information from available sources.
- Resulting lack of consideration of evidence relating to the intensity of Mr L's late mother's healthcare needs.
- No opportunity for the complainant to be involved in the process for determining his late mother's eligibility.

We upheld the complaint and requested that the PCT and SHA carry out a further review of Mr L's mother's eligibility for continuing care funding. We also recommended improvements to the process relating to evidence gathering and complainant involvement. On review, Mr L's late mother was found to have been eligible for funding for part of the period for which it was requested. The PCT asked Mr L to attend the panel meeting. They also met with him before the formal panel to discuss his concerns and explain the process. Mr L appreciated the opportunity to meet the people making the decision and to put forward his case.



Removal from a GP list

Mr C and his wife, Mrs C, were registered at the Practice for many years. Mrs C suffers from multiple sclerosis, is severely disabled, bed bound and unable to speak. She relies on Mr C and her carer, Mrs D, to attend to her needs, has daily visits from the District Nurse, and requires several prescribed medicines. In 2001, the Practice introduced a new system for processing repeat prescriptions: patients could no longer request them over the telephone but only in person or by post. Mr C complained about the new policy and asked if his wife could be treated as an exception, in view of her frequent, regular repeat prescriptions. The Practice refused. In May 2004, the PCT wrote to advise Mr C that both he and his wife were to be removed from the Practice list, due to a breakdown in the doctor-patient relationship and a refusal to change prescription habits. The Ombudsman investigated complaints that the removal was unjustified; no warning or discussion took place beforehand; and Dr A's actions were unprofessional and unreasonable.

We did not uphold the complaint that the removal was unjustified. A GP has the right to remove a patient from his list, and a breakdown in the doctor-patient relationship is a valid reason for this. The Ombudsman's Adviser said that there was evidence of a damaged relationship dating back to 2001, when Mr C made a very strongly worded complaint about the new repeat prescriptions policy. The policy itself was reasonable,

but the Practice experienced three years of difficulty trying to accommodate Mr C's and Mrs D's repeat prescription requests, which were regularly submitted without notice and late on a Friday evening.

On 1 March 2004 the rules changed. Patients cannot now be removed from a list unless they have been warned during the preceding 12 months that this might happen. This warning must be recorded. Mr C had been warned in 2001, in relation to his dissatisfaction with the repeat prescription policy, but the Practice took no action to remove Mr and Mrs C from the list at that time. This was, in any case, three years before the actual removal in May 2004 and thus was not a valid warning. The Practice maintained that further warnings were given in 2004, but did not provide any documentary evidence to corroborate that. We upheld the complaint to the extent that no adequate warning was given.

We did not uphold the complaint that Dr A behaved unprofessionally and unreasonably. The Ombudsman's Adviser could find no evidence that the removal was decided upon the grounds of Mrs C's high dependency, as suggested by Mr C. The catalyst had been the refusal to comply with the Practice's repeat prescription policy.

We recommended that Dr A should apologise to Mr C for the failure to give an adequate warning to Mr C, but he declined to do so. It is very rare for one of our recommendations to be rejected in this way.

Access to primary care

Removal of patients from GP lists

As in the past, the removal of patients from GP lists features significantly in the complaints against GPs that we concluded this year (32 complaints, or 23% of the total 139 complaints against GPs that we concluded). Before 2004, a GP could remove a patient from his or her list without giving the patient a reason, although guidance from the professional bodies acknowledged that it was good practice to give a reason. Many complainants who had been removed from their GPs' lists said that they had not had a warning or the opportunity to put their side of the story. To address this, the National Health Service (General Medical Services) Regulations 2004 changed the way GPs should approach removal cases: patients must be given a warning in the 12 months prior to removal; GPs are required to state clearly that the patient is at risk of being removed and must outline the reasons; a written record must be kept of any warning given; and GPs are required to give a reason when removing a patient.

The cases we concluded this year span the introduction of the new Regulations. Consequently, cases covering events before 2004 rarely included a warning to the patient. However, we note that this is also occurring in cases concerning events after the Regulations came into force. In some cases, GPs have given inadequate warnings – in one case citing as a 'warning' an event that

happened three years earlier, and in another an event seven years earlier. In others, GPs have relied on oral warnings but failed to keep a written record (see case study on page 36). We acknowledge that the Regulations had not been in force for long when most of these removals occurred and these may be isolated instances. However, it is of concern that some patients are still being removed without adequate warning.

Access to NHS dental services

Contrary to the position with GP registration, patients do not have a statutory right to be registered with an NHS dentist. NHS dentists can choose whether or not to treat NHS patients and there has been a fall in the number of dentists willing to carry out NHS work in recent years. In some areas, this has led to a marked reduction in the number of patients with access to an NHS dentist as the case study demonstrates. Although we did not uphold the series of complaints against the same PCT described, we recognised the frustration and inconvenience experienced by the complainants in attempting to gain access to regular NHS dental care.

Access to NHS dentistry

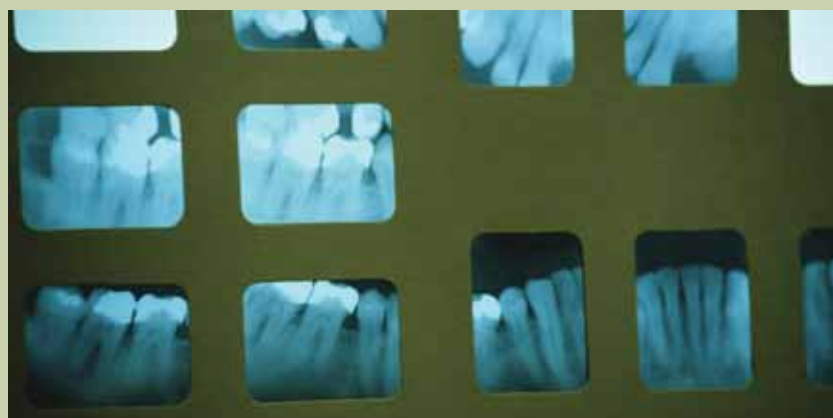
Ten people complained about access to NHS dentistry in the PCT area. They raised a number of issues, including: removal from a dentist's practice list when the dentist began to undertake only private work; inability to register with another NHS dentist since none were taking on new NHS patients; the distances involved in travelling to an alternative NHS dentist; delay in getting an appointment when a dentist was found who would undertake NHS work; the lack of NHS dentists available for people moving into the area; the way the PCT advertised the service which was available; and the role of the PCT's dental access team.

Taking account of professional advice from a consultant in public health dentistry in our investigation, we recognised that there is no right of access to an NHS dentist. In this PCT area, the reduction in the numbers of dentists willing to undertake NHS work had resulted in rates of access for adults that were lower than

regional and national levels.

However, the PCT had developed an action plan to improve access. This included the formation of a dental access team with a database of people wanting to be registered with an NHS dentist. The PCT used the database to allocate patients to any vacancies arising on the lists of dentists who accepted NHS patients.

We found that there was no evidence that people genuinely in need of emergency treatment had been denied. The PCT had taken reasonable steps to publicise the dental access team and to increase provision locally. The database in particular was a positive step in attempting to achieve a rational and fair allocation of patients. We observed that many of the crucial factors behind the experiences of the complainants were beyond the PCT's control, having arisen from national trends or policy and funding decisions. We did not uphold the complaint against the PCT.





Focusing on the patient?

A large number of complaints that we investigate concern a lack of patient focus. This is displayed in poor communication with patients and carers, flawed or inadequate care planning and lack of essential communication between different parts of the care spectrum. These features are particularly prevalent in cases concerning people with a mental illness and elderly people, especially those who are in psychiatric services.

The Mental Health National Service Framework (NSF), established in 1999,

focused on the provision of more therapeutic inpatient services; integrated services based on sound care planning; and the establishment of Crisis Intervention Services. Despite the NSF, it is disturbing to find that there are still instances of a lack of co-ordination of services and poor crisis management. The case of Mr W on page 39 illustrates all of these issues.

This year, we concluded a number of cases that highlight deficiencies in care planning and treatment for older people who are users of psychiatric services. The case of Mrs K on page 40 shows the impact of poor assessment and care planning and inadequate

communication both with the patient and her husband.

Many of the cases we investigate reveal problems of co-ordination and communication between different NHS bodies or services. This is often manifested in poor transfer documentation, meaning that receiving staff do not have sufficient information to care adequately for patients. In many cases, the patients involved are ill and find it hard to communicate, so are unable themselves to alert staff to relevant conditions or problems. The case of Mrs A on page 41 is an example.



Poor co-ordination between services and crisis management

Mr W suffered episodes of bipolar disorder over a number of years. He managed reasonably well at home with the support of a CPN, his GP and occasional visits to the psychiatrist. However, a change in accommodation and abuse from his neighbours brought about a crisis. He was admitted to hospital voluntarily but became concerned about his domestic arrangements. After a few days in hospital, he believed his health was improving and wanted to go home. However, staff felt uncertain about this and he became rather aggressive towards them when they asked him to await a psychiatrist's opinion. As a result, on two occasions, Mr W was restrained and the provisions of the Mental Health Act were applied to detain him.

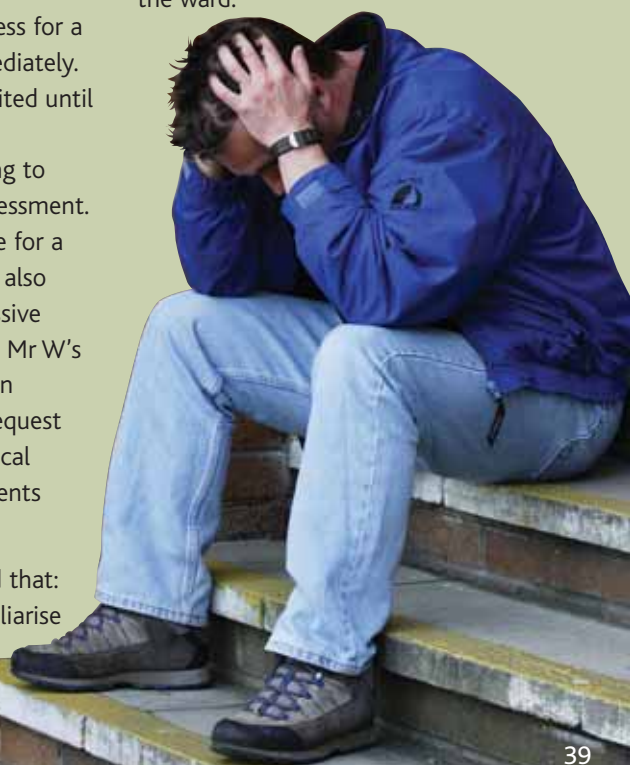
Mr W felt he was offered little in the way of therapy while he was an inpatient. He also felt that there was an over-reliance on the Mental Health Act and that the inpatient services did little to contact his CPN. He thought that if the acute services had done so, they would have felt confident to let him go home and sort out his domestic concerns. This would have helped him to calm down and he would either have continued his treatment at home or returned to hospital. His relationship with mental health services has broken down and he is managing as best he can with the help of his GP.

He now has a record of detention under the Mental Health Act, which he feels is unmerited.

Because matters escalated fairly quickly when Mr W first requested leave to go home, the Ombudsman felt that by the time the Consultant A became involved, he had little option in the circumstances but to detain and section Mr W. We also found it reasonable for Consultant B to refuse Mr W's second request without assessing him in person, and to wait before Mr W's Tribunal went ahead before discharging him. However, we found that: Consultant A's application of the Mental Health Act was flawed. Having decided to detain Mr W under Section 5.2, the appropriate action would have been to set into motion the process for a Section 2 assessment, immediately. As it was, he did not. He waited until he had seen Mr W again the following day before deciding to recommend a Section 2 assessment. Section 5.2 does not provide for a 'wait and see' approach. We also found that there were excessive numbers of staff involved in Mr W's first restraint; documentation relating to Mr W's second request was unsatisfactory; and clinical records relating to the incidents were inaccurate.

We therefore recommended that: Consultant A should re-familiarise himself with the

provisions of the Code of Practice relating to the Mental Health Act; that patients' CPNs should be contacted as a matter of routine when considering requests for leave and that any contact should be recorded; and the crisis resolution team should keep up to date information on patients, including relapse plans, and that co-ordination between the team and ward staff should be improved. We also recommended that the Trust should: consider adding to Mr W's records so that they more accurately reflect what actually occurred in relation to two alleged assaults on members of staff; and develop an information leaflet outlining the different models of therapeutic care carried out on the ward.



Inadequate nursing care for a patient with dementia and poor communication

Mr K cared for his wife at home for over 18 years and her needs increased after she developed dementia. Following a change in medication, her stability suffered, she experienced several falls and was admitted to the Trust. Mr K became increasingly concerned about the care his wife received: she had many accidents and falls and sustained injuries, two of which were severe enough to be treated in A&E. He also felt she was at risk from other patients, when staff did not intervene.

Staff were unable to give Mr K a satisfactory explanation for the injuries and trust between Mr K and ward staff began to break down. At one point, Mr K was

prevented from taking his wife home by a security guard and three nurses. The police were also called to the ward, which Mr K felt was completely unjustified. Trust staff alleged that Mr K had inappropriately restrained his wife on one occasion and compromised her dignity on another, which Mr K denied. During her three-month admission, Mrs K went from 10¹/₂ stone to slightly over 5 stone in weight. She also developed bedsores which were identified when she transferred to a nursing home.

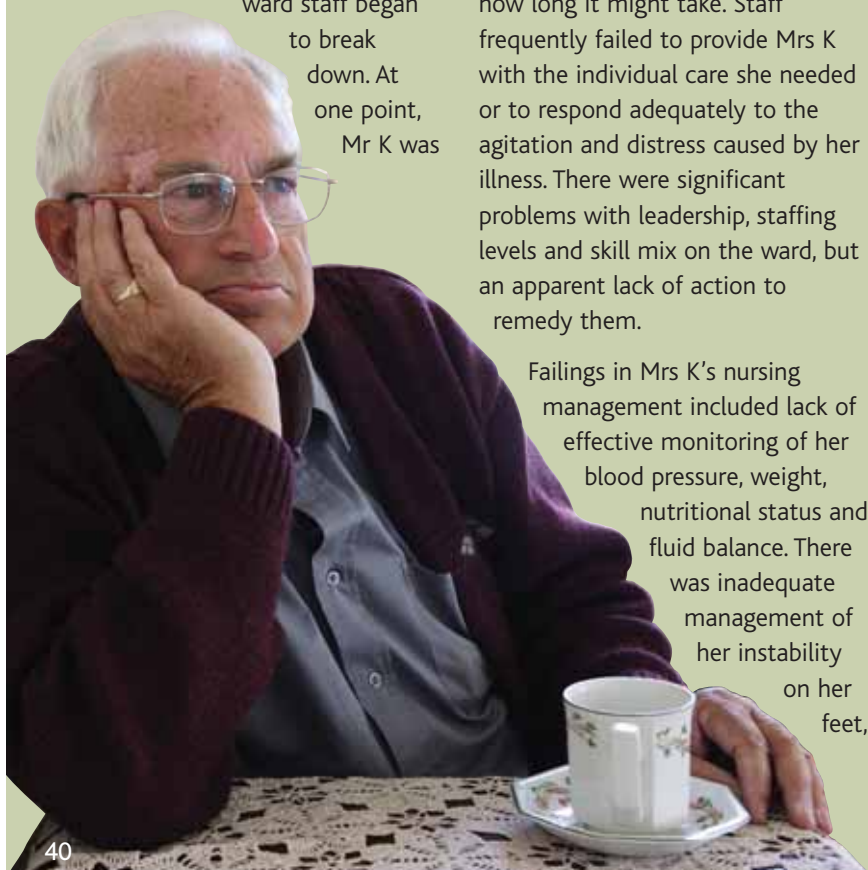
We found that the Trust had failed to explain the assessment process and how long it might take. Staff frequently failed to provide Mrs K with the individual care she needed or to respond adequately to the agitation and distress caused by her illness. There were significant problems with leadership, staffing levels and skill mix on the ward, but an apparent lack of action to remedy them.

Failings in Mrs K's nursing management included lack of effective monitoring of her blood pressure, weight, nutritional status and fluid balance. There was inadequate management of her instability on her feet,

a lack of monitoring of pressure areas and no proper assessment of Mrs K's need for the use of cot sides on her bed. Mr K's concerns for his wife's safety were not given sufficient weight and there was inadequate management of other, difficult patients.

We therefore considered that Mr K's concerns were entirely justifiable. We upheld his complaint that the Trust had failed to maintain an adequate relationship with him. We recognised that Mr K could express his views forcefully and staff had genuine problems with communication with him. However, there was no consistent attempt to address Mr K's fears or to address the relationship with ward staff. The overall medical management on the ward was reasonable, but we considered that doctors also had some responsibility for the overall failure in management and leadership.

The Trust accepted our recommendations, which included: actions to improve supervision, ward staffing levels and skill mix and reviewing training needs; the use of established systems for monitoring behaviour among dementia patients and implementation of National Service Frameworks for older people and mental health; reviewing its vulnerable adults policy; and providing psychology input for support staff and carers.



Care and treatment of a patient transferred between hospitals

Mrs A was admitted to Hospital A (part of the Trust) with a history of memory loss and a diagnosis of Alzheimer's Disease and multi-infarct dementia. She had a fall on the ward, fracturing her right arm and hip, and was transferred to Hospital B (also part of the Trust). She had a partial hip replacement and treatment of the right upper arm and was transferred back to Hospital A. She was then transferred to Hospital C (part of the PCT) for elective rehabilitation. After transferring to Hospital C, a physiotherapist recorded that Mrs A's right leg was shortened and externally-rotated. An X-ray showed that she had suffered a posterior dislocation of the right hip and she was admitted to Hospital B the same day. Staff there noted that her right hip was also fractured and that there was a further fracture of the right humerus. Mrs A had a total replacement of the hip, but was not fit enough for further surgery so the humerus was not treated.

Mrs A's husband and Mrs C, their daughter, complained to the PCT about Mrs A's care at Hospital C. Mr A believed that his wife had had a second fall, which had not been reported, while there.

In relation to the Trust, we found that it was not possible to identify when or how Mrs A sustained the fracture/dislocation of the hip. It was

found that there were technical inadequacies in each of the first operations on the right hip and right humerus, but there was insufficient evidence to suggest that these changed subsequent events.

In relation to the PCT, there was no evidence of Mrs A having fallen or been subject to unusual violence. It was found that her care and treatment were of a reasonable standard. However, we found that nursing staff at the PCT did not ensure they had sufficient information safely to care for Mrs A, and nursing documentation on her ability to mobilise and how she should be moved and handled was poor.

We recommended to the Trust that they should ensure that necessary equipment is anticipated when carrying out such operations and that surgeons should be informed when it is not available; and that adequate written transfer

information is given to receiving wards on transfer of patients and a copy kept in the patient's records.

We recommended to the PCT that: there should be weekend senior medical cover; relevant 'active' conditions should be explicitly noted when patients are transferred; entries in the medical notes should be made daily referring to the status of the active conditions; nursing staff should ensure they have sufficient information to care for patients transferred from other hospitals; training opportunities should be made available to all nurses so they can assess a patient's moving and handling requirements; a policy for the completion of core care plans should be introduced; a policy on the use of cot sides should be introduced and the use of them documented in the patient's notes; and pain assessment tools should be introduced.



Promoting good practice

We worked in various ways this year to further our aim to contribute to improvements in NHS service delivery. Our checklists for the assessment of continuing care complaints and visits to SHAs are an example. In addition, clinical advice that we commission to help us investigate cases is often of general use to NHS bodies. A PCT, on receipt of our investigation report into a complaint by Mrs P (HS-1761), commented that they had learned not only about the condition concerned but also about ways of improving their complaints system:

“We have noted that your clinical adviser has provided detailed background information about brain tumours. We believe that your adviser’s report has shed more light on the clinical decision making process, and the symptoms and incidence of brain tumour, than all previous efforts by the practice at the local resolution stage, or by the IRP [Independent Review Process]. The lesson learned ... is to encourage and facilitate the use of independent clinical advice where appropriate in dealing with complaints in future. We will amend our Complaints Policy and Procedures to include the option at the local resolution stage for an independent clinical adviser to discuss concerns with a complainant face to face, or to provide a written report.”



Improving communication with patients – informed consent to cardiac surgery

A significant number of complaints have concerned the quality and quantity of information patients have received before giving consent for surgery. Working with the Society of Cardiothoracic Surgeons (SCTS) of Great Britain and Ireland and other NHS bodies, we acted as an independent co-ordinator and facilitator in the production of a guide for cardiac teams on good practice for obtaining informed consent, which was launched in June 2005.

The booklet, *Consent in cardiac surgery: a good practice guide to agreeing and recording consent*, was based on detailed input and feedback from patients. The three-part guide is designed to ensure patients' genuine understanding of the risks associated with available treatments and to strengthen the patient's role in the decision making process.

The guide has received widespread support from all those consulted, with interest from other specialities in similar initiatives.





"This year, we have made good progress in developing our service, increasing our awareness of our customers' needs and responding to them more effectively."

Developing our service

One of the two top-level objectives in our strategic plan is to deliver a high quality complaints handling service to all who need it. We see continuous improvement and development as central to that.

This year, we have made good progress in developing our service, increasing our awareness of our customers' needs and responding to them more effectively.

Listening to the customer

In 2004, as we reported last year, we asked our stakeholders what they thought of our service. The public and those who advise them on complaints told us that they wanted us to be more proactive in initiating investigations and making sure that public bodies implement our recommendations. Complainants wanted us to communicate better and more regularly with them and to apply a more tailored approach to each complaint.

We listened to that message, and changed our approach, completely overhauling our processes and handling complaints in a new way from 1 April 2005.

The key features of the new approach are:

- Placing greater emphasis on clarifying with the complainant at the outset what result they are seeking. This enables us to specify clearly what we can and cannot help with.
- Developing a plan for each complaint which determines the most effective way of dealing with the complaint in question. Where it is appropriate, we use informal methods to achieve a satisfactory resolution.

- Keeping complainants regularly informed of progress on their complaint and sharing the drafts of our decisions with them as well as with the bodies complained against.
- Maintaining more regular contact with complaint handlers at the bodies complained against to check evidence and to gauge the feasibility of our recommendations.
- Following up our recommendations more consistently to ensure that appropriate action has been taken and the complainant informed before closing the case.

There is evidence that our customers welcome the new approach. This year we started to obtain data from our customer satisfaction survey, run for us by Ipsos MORI, to gauge how complainants felt about the way their complaint was dealt with. During the six months to 31 March 2006, of 579 complainants interviewed, 68% were very satisfied or satisfied with the way in which their complaint was handled. In addition, more than half (57%) spoke highly and positively of the



Ombudsman and the service provided, with large majorities considering us to be responsive, accessible, friendly and helpful. There were, however, areas for improvement, including in the time taken to allocate and investigate cases. As we continue to collect this data in future, we will have a larger sample to report against and we will be able to show comparative performance year on year.

Complaints about us

We also instituted a new internal complaints procedure for customers who have a complaint about our service. It aims to provide an accessible, simple and transparent process, respond quickly to complaints, provide appropriate redress if we have made a mistake and highlight general lessons for our work.

We received 948 complaints about our service during the year. We resolved 974 complaints, 74% of which were not upheld. Most complaints were in relation to the decision reached, although some related to the service received. In 3% of cases, we identified an error in the decision, while 16% needed a different or further explanation. We upheld 7% of complaints about our service, covering issues such as delay.

Customer views of our service

"It can be quite easy to be misunderstood when important issues are exchanged during conversations. It was very pleasant to talk to you and I did not feel misunderstood at all. Your accurately detailed follow-up letter was a pleasure to read, because you took the time to listen and this was conveyed over to me. You also took the time to write about my relevant points in a clear and courteous way." (Ms S, complainant)

"I really appreciated your calm, thorough and measured approach. I valued very much your communication at each stage and the way you e-mailed and phoned to keep me informed through this difficult and protracted process." (Mr U, complainant)

"Our views of the complaints process have certainly been negative but are now balanced by our dealings with you. We have not been used to people contacting us when or even before we expected it and we have appreciated your willingness to spend some time answering our questions regarding the process. I would be happy to characterize our contact with you as exemplary." (Mr C, complainant)

Learning from legal challenge

Learning can also come from legal challenge. One court case this year raised issues about the powers of the Office in its dealings with complainants. Applications for judicial reviews of the Ombudsman's decisions are rare. However, in November 2005, the Court of Appeal heard a judicial review brought against the Ombudsman by a complainant, Mr Redmond, and two doctors involved in the care of his daughter. The Court accepted that the Ombudsman has very wide discretion as to how she investigates a complaint. But it confirmed that she was only entitled to investigate matters that came within the terms of complaints submitted to her. In this case, the Court found that the Ombudsman had investigated a matter (the daughter's diagnosis) that did not fall within the terms of Mr Redmond's original complaint, which was about the medical treatment the Trust provided to his daughter.

This case is unlikely to affect the way the Ombudsman now investigates complaints. Our new approach to complaints handling, adopted since Mr Redmond's complaint was investigated, means that the remit of each complaint is agreed with the complainant at the outset. If an issue arises falling outside the original complaint, it is discussed with the complainant and the complaint is amended to include it, if the complainant agrees. If the complainant does not wish the additional issue to form part of the complaint, the



Ombudsman considers whether it is possible properly to investigate the original complaint without considering the new issue. If it is not, she may exercise her discretion to discontinue the investigation.

Tackling new responsibilities

Our approach to meeting customer needs involves anticipating changes that are likely to have a significant effect on our workload. In particular this year we have worked closely with other bodies to plan our approach to two new areas of responsibility and ensure that complainants receive a high quality service.

The phased transfer of responsibility for the healthcare of prisoners from

prisons to the NHS culminated in the final devolution of commissioning responsibility to Primary Care Trusts from 1 April 2006. Complaints by prisoners about the care they receive will now go through the NHS complaints system, with the Ombudsman as the third, and final, tier.

The Victims' Code came into effect on 1 April 2006. The Code carries a statutory entitlement for victims of crime to receive a minimum standard of service from criminal justice agencies. It gives the Ombudsman responsibility as the final arbiter of complaints alleging breaches of Code obligations by individual agencies. It also brings the Police and the Crown Prosecution Service within the Ombudsman's jurisdiction for the first time. During the year, we worked closely with the Home Office and the

Independent Police Complaints Commission to prepare for the introduction of the Code. We also liaised with Victim Support and other charities and support groups representing the needs of victims. This was crucial to gain an insight into and plan for the types and sources of complaints we might receive. We issued our own leaflet for victims who wish to complain to the Ombudsman, *The Victims' Code – how to complain*.

Improving access to our service

We are committed to providing access to a high quality complaints handling service to everyone who needs it. However, we know from the research we carried out in 2004 that awareness of our service is low, particularly among younger people and ethnic

minority groups. We also receive a large number of written complaints enquiries that are premature, indicating a lack of understanding of our role and jurisdiction.

During the year, we implemented a number of initiatives to improve our accessibility. The foremost of these has been starting work on an equality and diversity strategy to ensure that we integrate an understanding of these issues into all our work. We carried out a diversity audit with the assistance of a specialist company, Pearn Kandola, who looked both at external perceptions and staff views. We also started to identify more consistently the profile of our complainants through our customer satisfaction survey. We now capture a range of information about people who have had their complaints investigated by us, including ethnic background, age, gender, social class and disability

profile. The baseline data we obtain will enable us to draw up a strategy for this area.

An important means of reaching under-represented groups is through outreach work with advisory and mediation organisations, such as Citizens' Advice and the Independent Complaints Advocacy Service (ICAS) in the NHS. We have made considerable progress in this area this year. For example, staff from this Office made presentations about the Ombudsman to ICAS groups throughout the country, including what we can do, how people should use us and what they can expect when a case is sent to us. Our enhanced contacts with ICAS have resulted in fewer premature complaints being made by them and they have provided us with helpful feedback on our new approach to handling complaints.

Working together to develop our service

We regularly look to those beyond this Office to help us develop our service. This year we have continued to work with other Ombudsmen in the UK to share learning about complaint handling and consider issues of mutual interest. The Ombudsman has met other UK public sector Ombudsmen to discuss, among other things, the place of human rights in our work and cases that raise issues that cross UK borders.

The case of Mr and Mrs Balchin demonstrated the value of co-operation between the Office and the Local Government Ombudsmen, but it also underlined the limitations



imposed by our legislation. Work on the proposed Regulatory Reform Order (RRO), to facilitate joint improved working between the Local Government Ombudsmen and this Office, has continued. We hope that the Order will be in force soon, enabling us to carry out a much wider range of such work.

There is also increasingly a yet wider perspective. The Ombudsman attended a meeting of European colleagues at the Hague, at which the question of the application of EU law to the work of Ombudsmen was considered. In November she welcomed to London the European Ombudsman, Professor Nikiforos Diamandouros, who held talks with two Ministers including the Minister for Europe, members of Committees of both Houses of Parliament and members of the Council on Tribunals.

To help us keep in touch with major developments in public services, we also monitor the opinions of other stakeholders. To gauge and improve their awareness and understanding of our role and jurisdiction, we intend to carry out a regular stakeholder survey, starting in summer 2006. This will cover MPs, Permanent Secretaries, Chief Executives of NHS bodies, complainants, advisory bodies and a range of other organisations. We will report the results in our next Annual Report.

Principles of Good Administration

As part of our work to improve our service, we are developing a set of



principles of good administration. These are intended to provide a framework which can guide the Office when assessing standards of administration, informing the judgements we make when investigating complaints. We hope that they will also help promote a common understanding in departments and agencies, and among the public, of what constitutes good public administration.

Developing staff

We recognise that the successful introduction of very significant changes this year has relied on considerable commitment and high performance by staff. In the previous financial year, we recruited large numbers of new investigation staff and associate investigators, who needed

quickly to be trained and supported to achieve high levels of performance. To build on these achievements and to ensure that we continue to provide a high quality service, we focused this year on raising skill levels and enhancing leadership and management skills.

The results of the diversity audit that we carried out will be integrated into a diversity strategy and action plan during 2006, which will include a programme of training in this area for staff. This important piece of work aims to ensure that we recognise and are responsive to the differing needs and circumstances of our customers, and that our staff have both the competence and confidence to deal effectively with equality and diversity issues.



“We dealt with over 21,000 enquiries during the year. Of these, just over 3,500 were premature complaints and a further 1,000 were out of jurisdiction. These, taken together, made up 22% of total enquiries closed.”



Our workload and performance: Facts and figures

Workload, output and outcomes

Enquiries

We dealt with over 21,000 enquiries during the year. Of these, just over 3,500 were premature complaints and a further 1,000 were out of jurisdiction. These, taken together, made up 22% of total enquiries closed.

Figure 9
Number and types of enquiries 2005-06

Type of closed enquiry	Number	%
Requests for information	16,527	77%
Premature complaints	3,553	17%
Body out of jurisdiction	649	3%
Subject out of jurisdiction	439	2%
Other discretionary closures	229	1%
Total	21,397	100%

The figure of 11,689 enquiries reported on in 2004-05 is not directly comparable to the figure reported above due to changes in our procedure for recording enquiries.



Caseload

We began 2005-06 with 2,320 cases in hand. During the year we accepted 3,162 further cases for investigation.

Our output of completed cases fell during the first half of the year as we embedded our new business approach

and case management system. The number of cases in hand reached its highest point of 2,700 in October 2005. We implemented an action plan to clear the backlog of cases awaiting allocation and, as a result, by the year end we had concluded 25% more cases than we did in 2004-05 and reduced our overall caseload by 20%.

Figure 10

Cases accepted for investigation and concluded in 2005-06

	In hand at 1.4.05	Cases accepted for investigation in year	Cases reported on in year	Discontinued cases	In hand at 1.4.06
Parliamentary	1,012	1,853	1,715	15	1,135
Health – continuing care	744	553	1,097	3	197
Health – other	564	756	794	9	517
Health – total	1,308	1,309	1,891	12	714
Total	2,320	3,162	3,606	27	1,849
Total 2004-05	1,017	4,189	2,886	*	2,320



*Figure included in the previous column as recording procedures have changed.

Customer service standards

The high number of cases we had in hand at the start of the year,

combined with our slow start, meant that we failed to meet all but one of our customer service standards.

Waiting times have now reduced and we aim to continue that progress in the year ahead.

Figure 11

Performance against Customer Service Standards: Completion time from acceptance for investigation to report

	Health Standard (%)	Health Achieved (%)	Parliamentary Standard (%)	Parliamentary Achieved (%)
Within 3 months	30	25	80	38
Within 6 months	60	48	85	65
Within 12 months	90	88	95	99

Outcomes

Of the complaints we investigated in 2005-06, 37% were upheld in full, 30% upheld in part and 33% not upheld. A summary of complaint

outcomes is given in Figure 12 opposite. Detailed complaint outcomes, by body complained against, are included in the Government departments and agencies and NHS sections of this Report.

Figure 12
Outcome of complaints investigated 2005-06

	Upheld in full %	Upheld in part %	Not upheld %	Total %
Parliamentary	31%	23%	46%	100%
Health – continuing care	51%	41%	8%	100%
Health – other	27%	29%	44%	100%
Health – total	41%	36%	23%	100%
Total	37%	30%	33%	100%

Compliance with recommendations

Earlier in this report (on pages 11 and 13) we gave details of two reports we made to Parliament this year under section 10 (3) of the Parliamentary Commissioner Act 1967, indicating that the Government did not intend to remedy injustice that had been caused by maladministration. Generally, of the recommendations we made this year, over 99% were complied with; one exception was a GP who refused to apologise for removing a patient from his list. The majority of health recommendations focused on an apology or changes to a policy or procedure; others included procedural review, staff training or some other action to remedy the failure identified. The majority of parliamentary recommendations focused on financial compensation for inconvenience or distress; others included an apology, financial compensation for loss or an action to remedy the fault.

Fol and DPA Requests

During the year, we received 227 requests for information under the Freedom of Information Act (Fol). Of these, 123 were properly made under the Act; they included requests for information about our procedures, statistics and correspondence, and mainly came from members of the public. We responded to 87% within the 20 day deadline.

The remaining requests were largely from complainants seeking copies of information from their files and were therefore treated as requests for personal data under the Data Protection Act (DPA).

A review of our publication scheme is planned for 2006-07 which will take account of Fol requests to date; for the future, the scheme will be updated continuously in the light of Fol requests received.

During the year, 29 of the complaints about our service which we resolved included elements relating to Fol and/or DPA issues. Of these, 6 were upheld.





“We are committed to managing our resources effectively and to securing good value for money through sound and appropriate financial and governance arrangements.”



Managing our resources

We are committed to managing our resources effectively and to securing good value for money through sound and appropriate financial and governance arrangements. At the same time, we seek to be responsive to changes in demand for our services. In allocating budgets across the Office, our aim is to ensure that our key business objectives are achieved.

Our funding was previously agreed on an annual basis. In 2005-06, we agreed a three-year funding cycle with the Treasury to align with our first three-year strategic plan. The Office used resources of £22.592 million during the year in support of the activities outlined in this Report, with an underspend against budget of £0.195 million (0.8%).

The Parliamentary and Health Service Ombudsman Resource Accounts 2005-06 were laid before Parliament on 12 July 2006 and are available on the Office's website at www.ombudsman.org.uk or from The Stationery Office.

The Board as at March 2006



Ann Abraham
Parliamentary and Health Service
Ombudsman



Trish Longdon
Deputy Ombudsman



Bill Richardson
Deputy Chief Executive



Philip Aylett
Director of Strategy and
Communications



Linda Charlton
Director of Equality and Diversity



Andrew Puddephatt OBE
Audit Committee Chair



Tony Redmond
External Board Member



Cecilia Wells OBE
External Board Member



Annex A:

Governance and leadership

The post of Parliamentary and Health Service Ombudsman comprises two statutory roles – Parliamentary Commissioner for Administration (PCA) and Health Service Commissioner for England (HSCE)⁴.

The Ombudsman has sole responsibility and accountability for the work of the Office and the decisions that it takes. PHSO's non-statutory advisory Board, appointed in 2004, advises and supports the Ombudsman in providing leadership and good governance, as set out in the Office's Governance Statement⁵ and brings an external perspective to assist in the development of policy and practice.

The Board

The Board provides advice and support on:

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

The Audit Committee

The PHSO Audit Committee supports the Ombudsman (as Accounting Officer) and the Board in monitoring the adequacy of the Office's corporate governance and internal control systems. The Audit Committee is chaired by a non-executive, Andrew Puddephatt OBE, and comprises two other non-executive members (Tony Redmond, Chairman, Commission for Local Administration in England, and Jeremy Kean, Finance and IT Director of the Financial Ombudsman Service) and the Ombudsman.

⁴ The Ombudsman's powers are set out in the Parliamentary Commissioner Act 1967 and the Health Service Commissioners Act 1993.

⁵ Available on the website at www.ombudsman.org.uk/about_us/governance/governance_statement.html.

Ombudsman
Ann Abraham

Deputy Ombudsman
Trish Longdon

Operations
Investigation Directors
Carole Auchterlonie
Christine Corrigan
Valerie Harrison
Jack Kellett
Hilary York
Clinical Advice Director
Susan Lowson
Customer Service Manager
Damian Brady

Deputy Chief Executive
Bill Richardson

Corporate Resources
Finance Director
Graham Payne
Human Resources Director
Jon Ward
Service Delivery Director
Mark Castle-Smith

Director of Strategy & Communications
Philip Aylett

Director of Diversity & Equality
Linda Charlton

Legal Adviser
Anne Harding





Annex B:

Strategic Plan objectives 2006-09

Our aims and objectives for 2006-09 are:

Aim

To deliver a high quality complaints handling service to customers.

Objectives

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

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

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

Aim

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

Objectives

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

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

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

Three core priorities drive our work:

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



For more information on the Ombudsman's work and Strategic Plan 2006-09, please see the website at www.ombudsman.org.uk

About the Parliamentary and Health Service Ombudsman

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

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

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

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

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

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

Design and production www.dtw.co.uk



Printed on 100% recycled paper

Please note

The telephone numbers of the Parliamentary and Health Service Ombudsman changed on 15 March 2009.

The new contact details are:

Helpline: 0345 015 4033

Fax: 0300 061 4000

Millbank Tower
Millbank
London SW1P 4QP

Telephone 0845 015 4033

Fax 020 7217 4000

Email

phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

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