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Public Administration
and Constitutional Affairs
Committee (PACAC)

PHSO Annual Scrutiny 2017/18: Towards a Modern and Effective Ombudsman Service

Sixteenth Report of Session 2017–19

*Report, together with formal minutes
relating to the report*

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Public Administration and Constitutional Affairs Committee

The Public Administration and Constitutional Affairs Committee is appointed by the House of Commons to examine the reports of the Parliamentary Commissioner for Administration and the Health Service Commissioner for England, which are laid before this House, and matters in connection therewith; to consider matters relating to the quality and standards of administration provided by civil service departments, and other matters relating to the civil service; and to consider constitutional affairs.

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Contacts

All correspondence should be addressed to the Clerk of the Public Administration and Constitutional Affairs Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 3268; the Committee's email address is pacac@parliament.uk.

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Summary

The Parliamentary and Health Service Ombudsman (PHSO) is the complaint handler of last resort for individuals who have complaints about public services provided by UK Government Departments and the NHS in England. The Ombudsman is independent of the Government. The Public Administration and Constitutional Affairs Committee (PACAC) scrutinises the reports it lays before Parliament, including its annual report and accounts.

The PHSO has faced serious challenges in recent years, both external and internal, which led to a significant loss of public and stakeholder confidence in the organisation. A new Ombudsman, Mr Rob Behrens, was appointed in 2017. In 2018, following a recommendation from PACAC, the PHSO commissioned an Independent Peer Review to examine its ability to secure value for money in its work. The Peer Review concluded that “the [PHSO] is moving out of ‘critical care’ and into ‘recovery’. Overall, from facing a set of severe challenges, the organisation is on its way to becoming an efficient and effective modern ombudsman service ...”. Although the peer review panel had confidence in the strategy set by the PHSO’s new leadership, they warned against complacency. They also made strong arguments that, to improve their ability to improve public services, the Ombudsman should be given the power to begin investigations on their own initiative and to set standards for complaint handling by the NHS in England and Government Departments. These are issues the Committee concludes should be looked at as part of the long-delayed legislation to update and simplify public sector ombudsmen in England. The Committee’s predecessor called for new legislation in 2014, and the Government published a draft Bill in 2016 but has yet to progress it any further.

The apparent need for national standards for complaints systems stems from the perception that efforts to improve complaint handling in the NHS in England following the Mid Staffordshire and related scandals have, in the words of the Ombudsman, “fizzled out”. This is unacceptable. The Committee has invited the Ombudsman to lay a report before Parliament providing further evidence on this.

In 2017/18 the PHSO completed fewer investigations, more slowly. This reduction in productivity, they argue, was a result of the major restructuring of the organisation made necessary by the severe challenges the Peer Review subsequently identified, including a 24% real terms reduction in the PHSO’s funding between 2015/16 and 2018/19. However, the PHSO believes that because of the investment they have made in training new caseworkers and introducing new casework systems productivity has already improved in the current year. The Committee therefore expects to see improvements in their next annual report.

1 Introduction

1. The Parliamentary and Health Service Ombudsman combines the statutory roles of Parliamentary Commissioner for Administration and Health Service Commissioner for England.¹ As such the Ombudsman adjudicates on complaints that have not been resolved by the NHS in England and UK Government Departments. The post is currently held by Rob Behrens. There are separate ombudsman arrangements for local government services in England and for public services provided by the devolved governments.

2. The Ombudsman is supported by an organisation, also known as the Parliamentary and Health Service Ombudsman, with approximately 420 staff and an annual budget of approximately £32m.² For clarity, in this report we refer to Mr Behrens as “the Ombudsman” and the organisation he leads as the PHSO. Amanda Campbell is the Chief Executive of the PHSO.

3. The Ombudsman has discretion to choose which complaints he investigates. In 2017–18 he assessed 32,389 new complaints, of which he assessed 8,291 as being cases he could investigate, of these 2,429 were referred for investigation.³ PHSO completed 2,676 investigations in 2017–18, including complaints made in preceding years.⁴

4. The Ombudsman is independent of the Government, the NHS and Parliament. The postholder is accountable to Parliament, through the Public Administration and Constitutional Affairs Committee (PACAC), for the overall performance of the PHSO and for its use of resources.⁵ This has traditionally been through an annual evidence session based on the PHSO annual report and accounts. PACAC does not inquire into individual cases. However, the Ombudsman can lay reports before Parliament, often to highlight cases that he decides raise issues of wider concern, which the Committee (or another select committee) may then scrutinise. An example published during 2017/18 was *Ignoring the Alarms: How NHS eating disorder services are failing patients*, that was laid before Parliament on 8 December 2017.⁶

5. The Committee’s predecessor the Public Administration Select Committee also carried out longer inquiries into NHS complaints handling, *More Complaints Please!*,⁷ and the future of the PHSO, *Time for a People’s Ombudsman Service*, in 2013–14.⁸ *Time for a People’s Ombudsman* recommended clarifying and strengthening the Ombudsman’s accountability, as well as combining the jurisdictions of the PHSO and the Local Government and Social Care Ombudsman “to create a simpler and more straightforward Ombudsman’s service in England”.⁹ It also recommended reforming their powers to include the ability to carry out investigations on their own initiative, and to set local complaints handling standards [see Chapter 4].¹⁰

1 Parliamentary and Health Service Ombudsman, “[Who we are](#)” accessed 08 February 2019.

2 Parliamentary and Health Service Ombudsman, “[The Ombudsman’s Annual Report and Accounts 2017–18](#)”, HC1388, 18 July 2018, p 73 & 79

3 Ibid pp 17–20

4 Ibid p 23

5 [House of Commons “Standing Orders \(Public Business\)” HC 1020, 1 May 2018, Standing Order 146](#)

6 PHSO “[Ignoring the Alarms: How NHS eating disorder services are failing patients](#),” HC 634, 8 December 2017.

7 PASC, Twelfth Report of Session 2013–14, “[More Complaints Please!](#)” HC 229, 14 April 2014

8 PASC, Fourteenth Report of Session 2013–14, “[Time for a People’s Ombudsman Service](#)”, HC 655, 28 April 2014

9 Ibid para 83–88

10 Ibid paras 89–105

6. The Committee held its annual scrutiny session with the Ombudsman and Amanda Campbell on 22 January 2019. It also took evidence from Peter Tyndall and Dr Chris Gill, members of the Independent Peer Review panel [see chapter 2], on 9 January 2019. Questioning was focussed on the findings of the Independent Peer Review, the PHSO's performance in 2017/18 and the delivery of the early stages of its new strategy for 2018–21. The Committee also accepted 33 written submissions. The Committee is thankful to all those who contributed to the inquiry.

2 Independent Peer Review

7. In its report on the last annual scrutiny session, in response to the PHSO's evidence that they were likely to seek extra resources in the forthcoming spending review, the Committee recommended:

Given its past problems an external audit mechanism is required that will provide robust assurance of the value for money of the PHSO's operations to its Board, the Committee and the public. We recommend that the Ombudsman ask his non-executive directors to commission this and report back to us.¹¹

8. In July 2018 the PHSO's board appointed an "Independent Peer Review Panel" (the "panel") comprising Peter Tyndall, Ombudsman for the Republic of Ireland and President of the International Ombudsman Institute; Caroline Mitchell, Lead Ombudsman, Financial Ombudsman Service; and Dr Chris Gill, Lecturer in Public Law at the University of Glasgow.¹² The panel undertook a review of relevant literature and management data to establish a "quantitative and qualitative baseline for the study", followed by a two day study visit in August 2018.¹³ The panel's report was published on 12 November 2018.¹⁴

The Peer Review's Conclusions

9. The panel's overall conclusion was:

... under its current leadership, the [PHSO] is moving out of 'critical care' and into 'recovery'. Overall, from facing a set of severe challenges, the organisation is on its way to becoming an efficient and effective modern ombudsman service, which provides significant value for its stakeholders.¹⁵

10. The "severe challenges" the panel identified included external factors such as:

- outdated legislation which prevented it adopting modern ways of working;
- the "maze" of the public sector complaints system in England that generates significant extra demand on the PHSO in responding to enquiries from complainants whose complaints are either not ready for it to consider or are directed to the wrong body;
- and a 24% real terms reduction in its funding over the current spending review period ending in 2019/20.¹⁶

11. However, many challenges arose from issues within the PHSO's control including:

- "a loss of confidence by important stakeholders";
- "Governance and leadership failings leading to the early resignation of the previous ombudsman";

11 PACAC, Third Report of Session 2017–19, "PHSO Annual Scrutiny 2016–17" HC 492, 24 April 2018, para 20

12 Peter Tyndall, Caroline Mitchell, and Chris Gill "Value for Money Study: Report of the independent peer review of the Parliamentary and Health Service Ombudsman" 12 November 2018, para 1.2

13 *Ibid* para 1.5

14 *Ibid*

15 *Ibid* p2

16 *Ibid* paras 2.4–7

- “Failures in financial monitoring”;
- “Significant mistakes” in individual high-profile cases that had “caused significant damage to the PHSO’s reputation”; and
- A collapse in staff morale and confidence in the leadership of the PHSO.¹⁷

12. Although the PHSO “has a ways to go” according to Peter Tyndall,¹⁸ the panel concluded that it was on its “way to becoming an efficient and effective modern ombudsman service, which provides significant value for its stakeholders.”¹⁹ He and Dr Gill pointed to the significant improvement in staff morale, the data from the PHSO’s Customer Service Charter [See Chapter 3] and other sources, the new training and casework model that had been introduced, as well as their observations of staff and systems in operation as underpinning this conclusion.²⁰

13. Mr Tyndall also expressed his confidence that this “recovery” would be maintained, “because the foundations have been attended to with such detail and because of the leadership team”.²¹ However, he cautioned that this was not guaranteed and that the PHSO’s leadership would need to adapt as the reforms they had introduced matured.²² Mr Behrens agreed that the report was “not a basis for complacency”.²³

Value for Money

14. The panel concluded “that the PHSO’s recent reforms have significantly enhanced the efficiency of its operations and the value for money it is able to provide”, and that it provided good value for money compared to similar Ombudsmen.²⁴ This was based on a “contextual and holistic approach” to judging value, which took into account the value of the “advisory and signposting service” it provides to those caught in England’s “complaint maze” and the qualitative value of PHSO’s work to improve public services through its thematic reports, research and best practice guidance.²⁵ However, they accepted that there was limited systematic evidence on the impact of this work.²⁶

15. The panel had completed a direct comparison between the PHSO’s costs versus the number of complaints it handled (“cost per case”) and the Scottish Public Service Ombudsman, regarded as one of the “lower cost” of UK ombudsmen.²⁷ The panel produced three alternative “cost per case” metrics (see table 1 below) reflecting the PHSO and SPSO’s overall budgets divided by, respectively, every individual they had contact with (“cost per person helped”); every valid complaint they received whether it was investigated or not (“cost per complaint handled”); and for the number of completed investigations (“cost per investigation”).

17 Ibid paras 2.1–3. See also PACAC “PHSO Annual Scrutiny 2016–17” Paras 7–9

18 [Q7](#)

19 Tyndall et al “Value for Money Study” p 2. For an explanation of the characteristics of a “modern ombudsman service” see [Q1](#)

20 [Qq1–9](#) [Qq12–13](#) [Qq49–52](#)

21 [Q9](#)

22 [Q9](#)

23 [Q64](#)

24 [Q32](#) & Tyndall et al. “Value for Money Study” para 10.7

25 Ibid paras 10.6–7

26 [Q48](#)

27 [Qq39–41](#)

Table 1: Comparison of PHSO and SPSO cost per case metrics

Metric	PHSO	SPSO
Cost per person helped	£227	£501
Cost per complaint handled	£801	£716
Cost per investigation	£10,680	£2,617

Source: Tyndall et al. "Value for Money Study"

16. However, the panel cautioned against using "cost per case" as a measure of value for money owing to the lack of comparable data, the different caseloads between ombudsmen and its failure to capture the qualitative value of the PHSOs wider work. The panel highlighted the fact that the PHSO screens out substantially more of the complaints made to it at the pre-investigation phase than the SPSO, investigating only 8% of the complaints it receives compared to the SPSO's 24%. This reflects, in the panel's view, the comparatively large number of misdirected or premature complaints the PHSO receives.²⁸ They also argued that the PHSO's large proportion of health-related casework, 76% of complaints compared to 35% of the SPSOs, increased its costs owing to their added complexity and the cost of acquiring expert clinical advice.²⁹

17. Notwithstanding these concerns, Peter Tyndall told us that the figures did "suggest that there was value for money" from the PHSO.³⁰ He had, in fact, expected a "higher price differential" owing to the preponderance of health cases dealt with by the PHSO.³¹

18. Based on the evidence they presented we accept the Peer Review Panel's conclusion that the PHSO is "moving out of critical care and into recovery", and that it is "on its way to becoming an efficient and effective modern ombudsman service, which provides significant value for its stakeholders".³² We note Peter Tyndall's confidence in the leadership of the PHSO to continue this turn-around, but also his warning of the need to guard against complacency.

The peer review process

19. Peer review is a relatively new process in the ombudsman sector, and as Dr Gill explained several countries were considering how to evaluate ombudsmen's offices effectively.³³ A number of written submissions criticised the membership of the PHSO's peer review panel as being insufficiently independent as it contained two ombudsmen and an academic expert on ombudsmen (Dr Gill) who was formerly employed by the Scottish Public Sector Ombudsman.³⁴ The fact that the panel's chair was chosen, and its terms of reference were set, by the PHSO's board, (in-line with PACAC's recommendation) were also raised.³⁵

28 Tyndall et al. "Value for Money Study" para 4.5

29 Ibid para 4.6

30 [Q35](#)

31 [Q41](#)

32 Tyndall et al. "Value for Money Study" p2

33 [Q26](#)

34 A1 ([PSC0001](#)) A Kampalis ([PSC0017](#)) & Nicholas Wheatley ([PSC0032](#))

35 A1 ([PSC0001](#)) A Kampalis ([PSC0017](#)) & Wendy Morris ([PSC0018](#))

20. Mr Tyndall robustly defended his personal independence and that of his colleagues, noting their professional reputations relied on it.³⁶ He confirmed that the panel had “largely determined its own process” and that there had been no restriction on their access to talk to staff at the PHSO.³⁷ Mr Behrens pointed out that Mr Tyndall had selected his fellow panel members.³⁸ On the question of whether it might have been advantageous to have a member of the panel from a different sector both Mr Tyndall and Rob Behrens argued that it required expert experience from the sector, and that the experience with “generic consultancy companies” reviewing ombudsmen had not been positive.³⁹ However, Peter Tyndall did accept that it would be worth considering people with a wider range of experience in future reviews.⁴⁰

21. In his evidence Mr Tyndall also suggested that, on reflection, if he were to repeat the review he might seek to engage directly with people who had used the PHSO’s services alongside using the PHSO’s own customer satisfaction data.⁴¹ The lack of direct contact with complainants, rather than relying on the PHSO’s data, was criticised by several people who made written submissions.⁴²

22. Mr Tyndall also advised that it was necessary for such review processes to be repeated, potentially after three years, alongside the ongoing monitoring of performance and other data, to ensure that the expected changes had occurred.⁴³ The Ombudsman agreed that a peer review “every three or three and a half years” would be “a good discipline” for the PHSO.⁴⁴

23. The Committee has no doubt in the peer review panel’s personal independence and integrity. There is considerable value in the insight that leading practitioners and experts in a field, such as the panel that carried out this review, can bring. A single review, no matter how authoritative, is, however, only a snapshot. It will always have to be taken with the other available evidence, and that is how the Committee has approached it.

24. The Committee recommends that the PHSO repeat a peer review process every three to four years. For future reviews it also recommends that the PHSO considers how to reach outside the Ombudsman sector to obtain informed perspectives from professional peers with relevant experience in related sectors. This would potentially add further value to a review’s conclusions in the eyes of Parliament and the public. Engaging directly with people with direct experience of the PHSO’s service and other stakeholders would also add value and complement existing customer satisfaction data.

36 [Qq27–29](#)

37 [Q24](#) & [Q51](#)

38 [Q67](#)

39 [Q27](#) & [Q64](#)

40 [Q27](#)

41 [Q24](#)

42 Mr Richard Von Abendorff ([PSC0015](#)) A Kampalis ([PSC0017](#)) & Nicholas Wheatley ([PSC0032](#))

43 [Q13](#)

44 [Qq65–66](#)

3 PHSO's Performance in 2017/18

Productivity

25. In its written evidence the PHSO reported that

... we completed fewer cases in 2017–18 than the previous year and our waiting times increased.⁴⁵

As well as a 37% reduction in the number of investigations completed,⁴⁶ the PHSO also saw a backlog of cases awaiting assessment build up during 2017/18 peaking at 2,100 cases awaiting assessment in January 2018.⁴⁷ The average length of time for an investigation to be completed remained at 234 days, the same as the previous year which Amanda Campbell had described as unacceptable to the Committee in 2017.⁴⁸

26. This fall in performance was, the PHSO argued, owing to the “investment in recruitment and training” it had undertaken during the year reducing its productivity in the short-term.⁴⁹ Ms Campbell had predicted this would occur in evidence to the Committee in 2017.⁵⁰ This investment was part of the Ombudsman’s “rebuilding exercise” after he took over the role in April 2017.⁵¹ This was a task he described as “playing the piano and moving it upstairs at the same time” as he sought to “transform [the PHSO’s] operations and deliver our service at the same time”.⁵² Specifically just under a quarter of the PHSO’s posts had been transferred from London to Manchester, resulting in a need to recruit and train a “whole tranche of new, young graduates” to fill posts left by “experienced case handlers as a result of the move”.⁵³ Introducing a new case handling model during the period to streamline and improve how complaints are dealt with had required over 2,000 days of training for caseworkers, new and old.⁵⁴ Amanda Campbell reported that during the current financial year (2018/19) they had seen “significant productivity” improvements in response to this investment,⁵⁵ and as a result the backlog had been reduced to “frictional” levels reflecting the number of complaints arriving each month.⁵⁶

27. This picture of a temporary dip in performance resulting from the restructuring and relocation is supported by the findings of the peer review panel. It reported that the restructuring necessary to manage the PHSO’s reduced budget as well as the other challenges it faced had resulted in significant disruption, but in August 2018 when their study visit took place the panel found that it was “beginning to prove effective”.⁵⁷

45 Parliamentary and Health Service Ombudsman ([PSC0036](#))

46 [Q84](#)

47 [Q63](#)

48 [Q86](#)

49 Parliamentary and Health Service Ombudsman ([PSC0036](#))

50 [Q63](#)

51 [Q57](#)

52 [Q60](#)

53 [Q60](#)

54 [Q84](#)

55 [Q84](#)

56 [Q63](#)

57 Tyndall et al “Value for Money Study” para 5.7

28. The PHSO's dip in productivity in 2017/18 is unfortunate, especially following its performance in previous years. The Committee is very aware that this means that some individuals have suffered delays and poor service from the PHSO. However, it accepts that it is likely to be a consequence of the restructuring the Ombudsman had to carry out in 2017/18. Given the PHSO's evidence that the position had already improved in the current year and the backlog of cases had been cleared, the Committee expects to see improvements in 2018/19 and beyond.

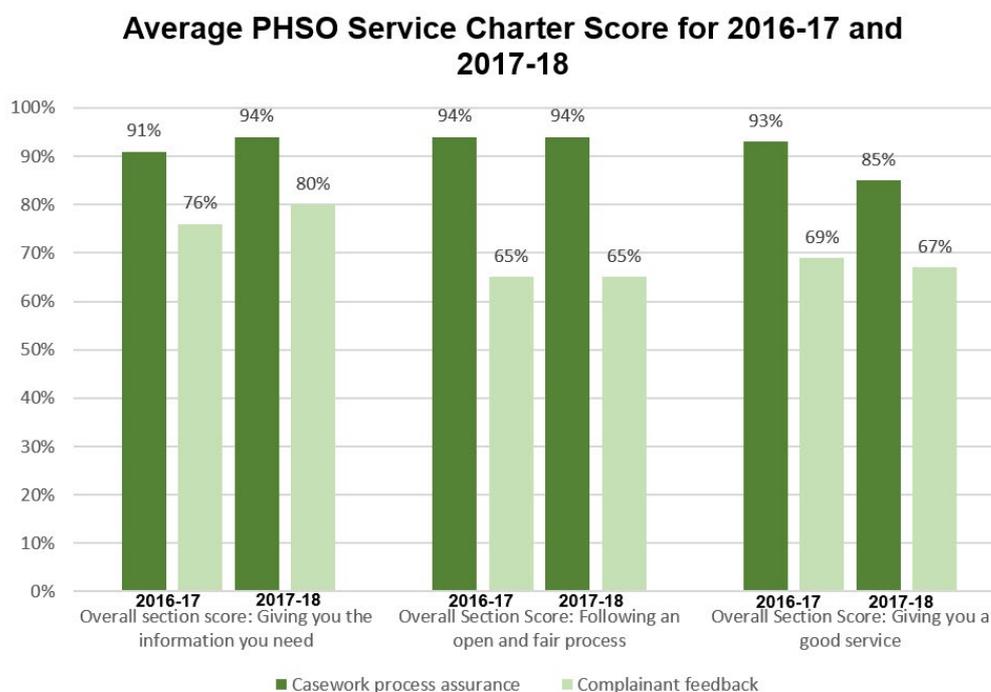
Service Quality

29. The PHSO introduced its Service Charter in the summer of 2016. This sets out 14 commitments to complainants about the service they can expect.⁵⁸ The PHSO publishes quarterly reports on its internal Casework Process Assurance against them, and the results of an independent survey of the views of 600 complainants.⁵⁹ The Service Charter is split into three themes:

- Giving the information you need;
- Following a fair and open process; and
- Giving you a good service.⁶⁰

In December 2017 Amanda Campbell explained to the Committee that there were no comparable organisations with similar data and therefore the PHSO would be tracking its performance over time rather than against external benchmarks.⁶¹

Figure 1 sets out the average score for each theme for 2016/17 and 2017/18.



58 Parliamentary and Health Service Ombudsman "[Our Service Charter](#)", accessed 14/02/2019

59 Ibid

60 Ibid

61 PACAC "PHSO Annual Scrutiny 2016-17" para 43

30. In their report the Peer Review panel confirmed that the PHSO's service charter was more sophisticated than most other UK public service ombudsmen, and that it represented an "impressive" amount and quality of data.⁶² In his oral evidence Chris Gill confirmed that the quality of the customer satisfaction data they had been able to access gave the panel confidence in their conclusions on the quality of the PHSO's service.⁶³

31. As is clear from figure 1, although the customer charter scores are stable a significant gap persists between the score derived from the PHSO's own casework process assurance and that from the complainant feedback survey. The PHSO explain this in large part as a result of complainant's views being influenced by the outcome of their complaint, with 85% of people whose complaint is upheld satisfied with the PHSO's service but only 49% of those whose complaint is not upheld.⁶⁴ Some complainants take the view that their negative view of the PHSO is a result of a perceived failure to investigate their complaint properly, which leads to a wrong decision not to uphold it, rather than the decision itself.⁶⁵

32. Large gaps also persist on some individual commitments. For example, on commitment 8, "We will gather all the information we need, including from you and the organisation you have complained about before we make our decision" the gap in 2017/18 between the internal casework process assurance and complaints' views was 52 percentage points, compared to 53 in 2016/17.⁶⁶ Amanda Campbell accepted that the score was "much lower than I would want".⁶⁷ She explained that the service charter data had been used to inform the design and content of the revised training for staff in order to address the issues it identified.

33. Last year the Committee highlighted the fact that the PHSO did not ask complainants views on the PHSO's commitment that "we will evaluate the information we've gathered and make an impartial decision on your complaint".⁶⁸ It recommended that the PHSO included the question in the future, given the importance of being perceived as impartial to the Ombudsman's effectiveness.⁶⁹ Perceived bias by PHSO staff towards public sector bodies and professionals remained a common theme in many of the written submissions the Committee received for this inquiry.⁷⁰

34. The PHSO has not added a question on impartiality to their complaint feedback survey as part of the service charter. Amanda Campbell explained that as part of their re-tendering of the charter they would be seeking to include focus groups to provide qualitative feedback, including potentially on issues of impartiality.⁷¹ However, she maintained that the impact of the PHSO's decisions on individual complaints "clouded" people's ability to assess the Ombudsman's impartiality.⁷²

62 Tyndall et al "Value for Money Study" para 9.2

63 [Q9](#)

64 [Q107](#)

65 Nicholas Wheatley ([PSC0032](#))

66 Parliamentary and Health Service Ombudsman "[Our Service Charter](#)" & PACAC "PHSO Annual Scrutiny 2016-17" para 44

67 [Q107](#)

68 PACAC "PHSO Annual Scrutiny 2016-17" para 47

69 Ibid para 51-52

70 For example, A2 ([PSC0008](#)) Chris Groves ([PSC0010](#)) Dr Kenneth Nicholson ([PSC0022](#)) Mrs Vanessa Wood ([PSC0027](#)) & Nicholas Wheatley ([PSC0032](#))

71 [Q111](#)

72 [Q111](#)

35. It is encouraging that the complainant feedback remained broadly stable during a period when, by its own admission, the PHSO's productivity dropped and backlogs built up. From a single year's figures, it is impossible to know if this is because the PHSO was successful in maintaining the quality of its service, even as it processed fewer cases more slowly, or if complainants' views as measured by the service charter are independent of the organisation's actual performance. We therefore expect to see an improvement in the service charter scores in the current and future years because of the Ombudsman's restructuring. Given that the PHSO has used the service charter to focus its revised training for staff on the areas where it is currently weakest we also expect to see this significant investment to be reflected in better scores in these areas.

36. Impartiality is the only issue the PHSO does not ask for complainant feedback on. As the Committee concluded last year public confidence in the Ombudsman's impartiality is core to his role. It is inevitable that the outcome of their specific complaint will colour some complainant's views of the PHSO. This, however, as the PHSO has strenuously argued, is true of many of the subjective issues the complainant feedback survey asks about. It is unclear why perceptions of impartiality are a special case that is not open to quantitative analysis.

37. *The Committee welcomes the PHSO's commitment to introduce a qualitative assessment of complainant's views of impartiality in the next service charter tender. However, unless strong evidence is provided to show why it is a special case, we stand by our recommendation that a question on impartiality should be included in the service charter survey.*

Staff and internal management

38. The Peer Review Panel's report concluded that in-terms of human resources, financial monitoring, corporate services as well the organisation's cultures and values, the "basic components of a well-managed public body... had previously not been in place or had not been working well."⁷³ As a result the PHSO's annual accounts for 2014/15 had been qualified by the National Audit Office and delivered late for 2015/16.⁷⁴ With regard to staff morale, according to Peter Tyndall, the Peer Review Panel "were astonished by the staff survey figures before the change process began—astonished", and concluded that the organisation was at a "very low ebb".⁷⁵

39. The peer review concluded that the PHSO now had internal management systems and process in in place that conformed "to sound management practice".⁷⁶ They also reported "very positive views expressed by staff members" who were "unanimous in their praise of the Ombudsman and the Chief Executive [Amanda Campbell]".⁷⁷ These conclusions are reinforced by the PHSO's staff survey results. The overall staff engagement index has risen from 52% in 2016, well below the Civil Service average, to 67% in October 2018 (following the peer review) above the benchmark of "high performing" Civil Service organisations.⁷⁸

73 Tyndall et al "Value for Money Study" para 5.3

74 PACAC "PHSO Annual Scrutiny 2016-17" para 9

75 [Q7](#)

76 Tyndall et al "Value for Money Study" para 5.3

77 Ibid para 5.4

78 Parliamentary and Health Service Ombudsman ([PSC0036](#))

40. The PHSO's leadership, and wider staff team, are to be congratulated on the evident turn around in the internal health of the organisation in such a short period. We attach great importance to the significant improvement in engagement index derived from the annual staff survey. This was however a recovery from a low base. That it was able to deteriorate to such a state indicates the ongoing need to reform its outdated governance and accountability arrangements to prevent such a failure in the future. This reinforces the need for legislation to be introduced as a matter of urgency.

41. *We therefore reiterate our predecessor committee's recommendations from 2014 on the need for fundamental reform of the PHSO's governance. This will require legislation. The Government and Parliament must ensure that the Draft Public Service Ombudsman Bill is scrutinised by a Joint Committee of both Houses of Parliament as soon as possible. It is disappointing that the draft Bill has been waiting for pre-legislative scrutiny since it was published in December 2016. The Bill must then be included in the Government's legislative programme at the earliest opportunity, or it will continue to be much harder than necessary for PHSO to continue and to sustain its recovery.*

4 PHSO's role in improving public services

42. The independent peer review argued that:

The value of the PHSO is not restricted to resolving disputes between citizens and public bodies. There is a broader systemic value to its work, where dealing with complaints provides information that allows for change in public services.⁷⁹

This is in-line with the PHSO's strategy which has "working in partnership to improve public services, especially frontline complaint handling" as one of its three objectives.⁸⁰ In oral evidence Peter Tyndall explained that he had always thought that "the core role of a public service ombudsman is twofold: investigating complaints and improving services". The peer review concluded that the Ombudsman could deliver more value on the second role if he had the power to carry out investigations on his own initiative, not just into individual complaints he receives ("own initiative powers"); and the ability to set standards for how public services handle complaints before they reach the Ombudsman (acting as a "Complaints Standard Authority").⁸¹

43. However, several of those submitting written evidence argued that the Ombudsman's sole role should be adjudicating individuals' complaints, with any improvement in public services coming as a result of his upholding them.⁸² One complainant, for instance, argued that wider engagement and improvement work was a "siphoning of resources away from casework to other, "softer" operations [and] therefore does not truly represent value for money".⁸³

44. Responding to this Dr Gill pointed out that, according to research by the National Audit Office, less than half of people unhappy with a public service would complain, and fewer still would escalate their complaint to an Ombudsman. Therefore, in his view, "if the ombudsman is only serving individual complainants, then it is not serving the public".⁸⁴ Mr Behren's "brave hope" was that the PHSO's work improving services would in the long-term reduce the number of people feeling the need to complain to the PHSO.⁸⁵

45. The Committee agrees with Dr Gill that "if the ombudsman is only serving individual complainants, then it is not serving the public". Impartially adjudicating complaints and providing redress to individuals who have suffered injustice or harm is its first responsibility. However, of itself, that is too narrow an interpretation of the Ombudsman's role, and it is right to consider how else he can improve public services and potentially prevent people from suffering harm or injustice in the first place.

79 Tyndall et al "Value for Money Study" p 3

80 PHSO "Annual Report and Accounts 2017-18" p15

81 Tyndall et al "Value for Money Study" para 7.3

82 Wendy Morris ([PSC0018](#)) Della Reynolds ([PSC0021](#))

83 Alan Reid ([PSC0005](#))

84 [Q22](#)

85 [Q94](#)

Systemic issues and “own initiative” powers

46. Peter Tyndall highlighted the PHSO’s “systemic work”, using the findings from individual investigations, or groups of linked ones, to make recommendations for wider reform to improve services, as a particular historic and ongoing strength of the organisation.⁸⁶ In his evidence Rob Behrens pointed to the impact that the PHSO’s thematic report on Eating Disorders had had in stimulating “significant progress” within the NHS.⁸⁷ The PHSO has also committed to moving to a default of publishing all its decisions in order to allow the public, professionals and researchers to track trends in its casework and hold organisations to account.⁸⁸

47. However, the PHSO’s systemic work is limited by the fact that the Ombudsman can only investigate valid complaints that have been made to him.⁸⁹ Peter Tyndall explained how, as Irish Ombudsman, he could expand an investigation to look at whether the injustice he found in one case was a systemic issue or an isolated case, without first receiving further complaints.⁹⁰ He gave the example of investigating whether a mistake in calculating social rents made by one local authority was being repeated by others, that resulted in several other people receiving refunds who did not even know they had been overcharged.⁹¹

48. He also highlighted the potential for the Ombudsman to investigate cases where he had evidence of injustice but no specific complaint; often because the individuals involved were vulnerable and/or unwilling to make a complaint in their own name for fear of retribution.⁹² Rob Behrens suggested that it “undermined confidence [in the PHSO] when people think that we are ignoring an issue” that was very high profile, but he had not received a legitimate complaint he could investigate.⁹³ He also noted that three quarters of ombudsmen in other countries had own initiative powers, and England was seen as being behind the times in this regard.⁹⁴ In its 2014 report *Time For a People’s Ombudsman Service* the Committee’s predecessor recommended that the new Public Service Ombudsman be given an own initiative power.⁹⁵ However, it was not included in the draft Bill.⁹⁶ In 2018 the Northern Irish Ombudsman gained these powers and has launched her first investigations under them.⁹⁷

Local Complaints and “Complaints Standards Authority” powers

49. The quality of how local NHS bodies deal with complaints about their services is a longstanding concern of this Committee and its predecessors, including the 2014 PASC Report *More Complaints Please*.⁹⁸ In his evidence last year the Ombudsman highlighted

86 [Q8](#)

87 [Q89](#) & [correspondence from Rob Behrens 5 February 2019](#)

88 [Q96](#)

89 [Q100](#)

90 [Qq19–20](#)

91 [Q20](#)

92 [Q19](#)

93 [Q100](#)

94 [Q93](#)

95 PASC “Time for a People’s Ombudsman Service” para 72

96 Cabinet Office “[Draft Public Services Ombudsman Bill](#)”, CM 9374, 5 December 2016

97 Northern Ireland Public Services Ombudsman, “[Own Initiative Investigations](#)” accessed 11/03/2019

98 PASC, “[More Complaints Please!](#)”. Our and the Health Committee’s recent reports touching on this issue are summarised in PACAC “PHSO Annual Scrutiny 2016–17” paras 64–68

the impact failures in local complaint handling had on individuals, and on the PHSOs caseload as it received more, and more complex, complaints that could have been resolved locally.⁹⁹ In its report the Committee called on the Government to set out its proposals for improving the situation, and fulfilling its previous commitments.¹⁰⁰

50. Asked if the situation had improved Mr Behrens was blunt.

*No ... What [NHS complaint handlers] say to me in private is that they want help, they don't have the necessary resource, they don't have the appropriate status, and they don't have skills or training, which makes it very difficult for them to call into question the judgments of clinicians in hospitals. That should be a matter of concern for us all [emphasis added].*¹⁰¹

He later explained that despite the improvements that had been made following the publication of the Francis Report into Mid Staffordshire NHS Foundation Trust in 2013;¹⁰²

*... my judgement is that the momentum for a more effective incisive complaints handling service across the NHS has fizzled out.*¹⁰³

51. In its response to the Committee's last annual scrutiny report that criticised its failure to deal with this "unfinished business", the Government promised to "share details of the revised Strategy [for handling complaints across the care system] with the Committee in the autumn."¹⁰⁴ It did not.

52. Although the PHSO's strategy includes work to support the improvement of local complaint handling through the sharing of best practice, and potentially training, both the independent peer review and the Ombudsman have argued it could do more.¹⁰⁵ They advocated giving the PHSO (or its successor) a statutory role in setting and regulating standards for local complaints handling within the public sector in England.¹⁰⁶ The Scottish Public Services Ombudsman already has this role as the Scottish Complaints Standards Authority.¹⁰⁷ Both Mr Tyndall and the Ombudsman highlighted the fact that the Scottish Ombudsman only has three members of staff devoted to this role as evidence that it would be unlikely to distract from the PHSO's other work.¹⁰⁸ PASC recommended in 2014 that the proposed reform of Ombudsman legislation should give the PHSO or its successor "the power to oversee complaints processes across its area of jurisdiction, and a formal role in setting standards and training in complaints handling."¹⁰⁹

53. In 2016 the Government published a draft Public Service Ombudsman Bill, which would create a new public service ombudsman for England combining the roles of the PHSO with the Local Government and Social Care Ombudsman and updating its powers

99 [ibid](#)

100 [ibid](#)

101 [Q78](#)

102 Robert Francis QC "Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry" HC 947, 6 February 2013.

103 [Q79](#)

104 PACAC Sixth Special Report of Session 2017–19 "[PHSO Annual Scrutiny 2016–17: Government and PHSO Response to the Committee's Third Report](#)", HC 1497, 25 July 2018, appendix 1.

105 [Qq16–19](#) & [Q81](#)

106 [Qq16–19](#) & [Q81](#)

107 [Q81](#) see also SPSO "[Complaints Standards Authority](#)" [accessed 18/02/2019]

108 [Q19](#) & [Q81](#)

109 PASC "Time for a People's Ombudsman" para 77.

and governance.¹¹⁰ This did not include these powers, but Mr Behrens suggested that when it came before Parliament it would provide a “once-in-a-generation opportunity” to address these and other issues.¹¹¹ The Government has yet to commit to either introducing the Bill or submitting it to a Joint Committee of both Houses for pre-legislative scrutiny as this Committee recommended last year.¹¹²

54. Based on the clear and strong evidence from the members of the Independent Peer Review we reiterate the recommendation of our predecessor committee, PASC, that the Ombudsman should have the power to begin or expand investigations on his own initiative and be able to set local complaint handling standards. *The Government should carefully consider the case made by the independent peer review panel when it decides to take the legislation forward.*

55. The loss of momentum on the proposed Public Services Ombudsman Bill is disappointing. Given his detailed knowledge of the issue the Ombudsman’s view that momentum on improving local NHS complaints handling has “fizzled out”, despite the repeated conclusions of this and other Select Committees on the need for them to improve, is very concerning. Such a fizzling out would be unacceptable. We support the PHSO’s work to improve complaints in partnership with others. However, the PHSO cannot address a lack of resources or a failure to take complaints seriously within the NHS. That is a matter for Ministers and NHS England. *The Committee invites the Ombudsman to use his powers to lay a report before Parliament setting out the PHSO’s insight from its casework into the state of local complaints handling in the NHS, and Government Departments. We also expect the Department for Health and Social Care to provide the update on its strategy on complaints that was promised last year as a matter of urgency.*

110 Cabinet Office “[Draft Public Services Ombudsman Bill](#)”

111 [Q81](#)

112 PACAC “PHSO Annual Scrutiny 2016–17” para 5

Conclusions and recommendations

Independent Peer Review

1. Based on the evidence they presented we accept the Peer Review Panel's conclusion that the PHSO is "moving out of critical care and into recovery", and that it is "on its way to becoming an efficient and effective modern ombudsman service, which provides significant value for its stakeholders". We note Peter Tyndall's confidence in the leadership of the PHSO to continue this turn-around, but also his warning of the need to guard against complacency. (Paragraph 18)
2. The Committee has no doubt in the peer review panel's personal independence and integrity. There is considerable value in the insight that leading practitioners and experts in a field, such as the panel that carried out this review, can bring. A single review, no matter how authoritative, is, however, only a snapshot. It will always have to be taken with the other available evidence, and that is how the Committee has approached it. (Paragraph 23)
3. *The Committee recommends that the PHSO repeat a peer review process every three to four years. For future reviews it also recommends that the PHSO considers how to reach outside the Ombudsman sector to obtain informed perspectives from professional peers with relevant experience in related sectors. This would potentially add further value to a review's conclusions in the eyes of Parliament and the public. Engaging directly with people with direct experience of the PHSO's service and other stakeholders would also add value and complement existing customer satisfaction data.* (Paragraph 24)

PHSO's Performance in 2017/18

4. The PHSO's dip in productivity in 2017/18 is unfortunate, especially following its performance in previous years. The Committee is very aware that this means that some individuals have suffered delays and poor service from the PHSO. However, it accepts that it is likely to be a consequence of the restructuring the Ombudsman had to carry out in 2017/18. Given the PHSO's evidence that the position had already improved in the current year and the backlog of cases had been cleared, the Committee expects to see improvements in 2018/19 and beyond. (Paragraph 28)
5. It is encouraging that the complainant feedback remained broadly stable during a period when, by its own admission, the PHSO's productivity dropped and backlogs built up. From a single year's figures, it is impossible to know if this is because the PHSO was successful in maintaining the quality of its service, even as it processed fewer cases more slowly, or if complainants' views as measured by the service charter are independent of the organisation's actual performance. We therefore expect to see an improvement in the service charter scores in the current and future years because of the Ombudsman's restructuring. Given that the PHSO has used the service charter to focus its revised training for staff on the areas where it is currently weakest we also expect to see this significant investment to be reflected in better scores in these areas. (Paragraph 35)

6. Impartiality is the only issue the PHSO does not ask for complainant feedback on. As the Committee concluded last year public confidence in the Ombudsman's impartiality is core to his role. It is inevitable that the outcome of their specific complaint will colour some complainant's views of the PHSO. This, however, as the PHSO has strenuously argued, is true of many of the subjective issues the complainant feedback survey asks about. It is unclear why perceptions of impartiality are a special case that is not open to quantitative analysis. (Paragraph 36)
7. *The Committee welcomes the PHSO's commitment to introduce a qualitative assessment of complainant's views of impartiality in the next service charter tender. However, unless strong evidence is provided to show why it is a special case, we stand by our recommendation that a question on impartiality should be included in the service charter survey.* (Paragraph 37)
8. The PHSO's leadership, and wider staff team, are to be congratulated on the evident turn around in the internal health of the organisation in such a short period. We attach great importance to the significant improvement in engagement index derived from the annual staff survey. This was however a recovery from a low base. That it was able to deteriorate to such a state indicates the ongoing need to reform its outdated governance and accountability arrangements to prevent such a failure in the future. This reinforces the need for legislation to be introduced as a matter of urgency. (Paragraph 40)
9. *We therefore reiterate our predecessor committee's recommendations from 2014 on the need for fundamental reform of the PHSO's governance. This will require legislation. The Government and Parliament must ensure that the Draft Public Service Ombudsman Bill is scrutinised by a Joint Committee of both Houses of Parliament as soon as possible. It is disappointing that the draft Bill has been waiting for pre-legislative scrutiny since it was published in December 2016. The Bill must then be included in the Government's legislative programme at the earliest opportunity, or it will continue to be much harder than necessary for PHSO to continue and to sustain its recovery.* (Paragraph 41)

PHSO's role in improving public services

10. The Committee agrees with Dr Gill that "if the ombudsman is only serving individual complainants, then it is not serving the public". Impartially adjudicating complaints and providing redress to individuals who have suffered injustice or harm is its first responsibility. However, of itself, that is too narrow an interpretation of the Ombudsman's role, and it is right to consider how else he can improve public services and potentially prevent people from suffering harm or injustice in the first place. (Paragraph 45)
11. Based on the clear and strong evidence from the members of the Independent Peer Review we reiterate the recommendation of our predecessor committee, PASC, that the Ombudsman should have the power to begin or expand investigations on his own initiative and be able to set local complaint handling standards. *The Government should carefully consider the case made by the independent peer review panel when it decides to take the legislation forward.* (Paragraph 54)

12. The loss of momentum on the proposed Public Services Ombudsman Bill is disappointing. Given his detailed knowledge of the issue the Ombudsman's view that momentum on improving local NHS complaints handling has "fizzled out", despite the repeated conclusions of this and other Select Committees on the need for them to improve, is very concerning. Such a fizzling out would be unacceptable. We support the PHSO's work to improve complaints in partnership with others. However, the PHSO cannot address a lack of resources or a failure to take complaints seriously within the NHS. That is a matter for Ministers and NHS England. The Committee invites the Ombudsman to use his powers to lay a report before Parliament setting out the PHSO's insight from its casework into the state of local complaints handling in the NHS, and Government Departments. We also expect the Department for Health and Social Care to provide the update on its strategy on complaints that was promised last year as a matter of urgency. *The Committee invites the Ombudsman to use his powers to lay a report before Parliament setting out the PHSO's insight from its casework into the state of local complaints handling in the NHS, and Government Departments. We also expect the Department for Health and Social Care to provide the update on its strategy on complaints that was promised last year as a matter of urgency.* (Paragraph 55)

Formal minutes

Tuesday 19 March 2019

Members Present

Sir Bernard Jenkin, in the Chair

Ronnie Cowan Mr David Jones

Dr Rupa Huq Eleanor Smith

David Morris

Draft Report *PHSO Annual Scrutiny 2017/18: Towards a Modern and Effective Ombudsman Service* proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraph 1 to 55 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Sixteenth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order 134.

[Adjourned till Tuesday 26 March 2019 at 09.30am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 8 January 2019

Peter Tyndall and Dr Chris Gill

[Q1-54](#)

Tuesday 22 January 2019

Rob Behrens, Parliamentary and Health Service Ombudsman, and **Amanda Campbell**, Chief Executive Officer and Deputy Ombudsman, Parliamentary and Health Service Ombudsman

[Q55-125](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

PSC numbers are generated by the evidence processing system and so may not be complete.

- 1 A Kampalis ([PSC0017](#))
- 2 A1 . ([PSC0001](#))
- 3 A2 . ([PSC0008](#))
- 4 AEA Technology Pensions Campaign ([PSC0028](#))
- 5 Alan Reid ([PSC0005](#))
- 6 BMA ([PSC0037](#))
- 7 Brenda Prentice ([PSC0006](#))
- 8 Chris Groves ([PSC0010](#))
- 9 David Czarnetzki ([PSC0031](#))
- 10 David Matthews ([PSC0035](#))
- 11 Della Reynolds ([PSC0021](#))
- 12 Dr Kenneth Nicholson ([PSC0022](#))
- 13 Dr Minh Alexander ([PSC0025](#))
- 14 Elise Holton ([PSC0034](#))
- 15 M Boyce ([PSC0014](#))
- 16 Maggie and Janet Brooks ([PSC0030](#))
- 17 Miss Margaret Brown ([PSC0002](#))
- 18 Miss Peggy Banks ([PSC0003](#))
- 19 Mr Colin N Rock ([PSC0024](#))
- 20 Mr Edwin Harper ([PSC0026](#))
- 21 Mr Julian Stell ([PSC0029](#))
- 22 Mr Richard Von Abendorff ([PSC0015](#))
- 23 Mrs Margaret Whalley ([PSC0019](#))
- 24 Mrs Teresa Steele ([PSC0012](#))
- 25 Mrs Vanessa Wood ([PSC0027](#))
- 26 Ms Janet E. Brooks ([PSC0033](#))
- 27 Ms Rosamund Ridley ([PSC0009](#))
- 28 Nicholas Wheatley ([PSC0032](#))
- 29 Parliamentary and Health Service Ombudsman ([PSC0036](#))
- 30 Paul Roditelev ([PSC0038](#))
- 31 phso the facts ([PSC0011](#))
- 32 Ron Prentice ([PSC0020](#))
- 33 Wendy Morris ([PSC0018](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2017–19

First Report	Devolution and Exiting the EU and Clause 11 of the European Union (Withdrawal) Bill: Issues for Consideration	HC 484
Second Report	Parliamentary Boundary Reviews: What Next?	HC 559 (HC 1072)
Third Report	PHSO Annual Scrutiny 2016–17	HC 492 (HC 1479)
Fourth Report	Ensuring Proper Process for Key Government Decisions: Lessons Still to be Learned from the Chilcot Report	HC 854 (HC 1555)
Fifth Report	The Minister and the Official: The Fulcrum of Whitehall Effectiveness	HC 497 (HC 1977)
Sixth Report	Accounting for Democracy Revisited: The Government Response and Proposed Review	HC 1197
Seventh Report	After Carillion: Public sector outsourcing and contracting	HC 748 (HC 1685)
Eighth Report	Devolution and Exiting the EU: reconciling differences and building strong relationships	HC 1485 (HC 1574)
Ninth Report	Appointment of Lord Bew as Chair of the House of Lords Appointments Commission	HC 1142
Tenth Report	Pre-Appointment Hearings: Promoting Best Practice	HC 909 (HC 1773)
Eleventh Report	Appointment of Mr Harry Rich as Registrar of Consultant Lobbyists	HC 1249
Twelfth Report	Appointment of Lord Evans of Weardale as Chair of the Committee on Standards in Public Life	HC 930 (HC 1773)
Thirteenth Report	A smaller House of Lords: The report of the Lord Speaker's committee on the size of the House	HC 662 (HC 2005)
Fourteenth Report	The Role of Parliament in the UK Constitution Interim Report The Status and Effect of Confidence Motions and the Fixed-term Parliaments Act 2011	HC 1813 (HC 2065)
Fifteenth Report	Status of Resolutions of the House of Commons	HC 1587 (HC 2066)
First Special Report	Will the NHS ever learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England: Government Response to the Committee's Seventh Report of Session 2016–17	HC 441

Second Special Report	The Future of the Union, part two: Inter-institutional relations in the UK: Government Response to the Sixth Report from the Committee, Session 2016–17	HC 442
Third Special Report	Lessons still to be learned from the Chilcot inquiry: Government Response to the Committee’s Tenth Report of Session 2016–17	HC 708
Fourth Special Report	Government Response to the Committee’s Thirteenth Report of Session 2016–7: Managing Ministers’ and officials’ conflicts of interest: time for clearer values, principles and action	HC 731
Fifth Special Report	Parliamentary Boundary Reviews: What Next?: Government Response to the Committee’s Second Report	HC 1072
Sixth Special Report	PHSO Annual Scrutiny 2016–17: Government and PHSO Response to the Committee’s Third Report	HC 1479
Seventh Special Report	Ensuring Proper Process for Key Government Decisions: Lessons Still to be Learned from the Chilcot Report: Government Response to the Committee’s Fourth Report	HC 1555
Eighth Special Report	Government Response to the Committee’s Eighth Report: Devolution and Exiting the EU: reconciling differences and building strong relationships	HC 1574
Ninth Special Report	Government Response to the Committee’s Seventh Report: After Carillion: Public sector outsourcing and contracting	HC 1685
Tenth Special Report	Government Response to the Committee’s Tenth Report: Pre-Appointment Hearings: Promoting Best Practice, and to the Committee’s Twelfth Report: Appointment of Lord Evans of Weardale as Chair of the Committee on Standards in Public Life	HC 1773
Eleventh Special Report	Government Response to the Committee’s Fifth Report: The Minister and the Official: The Fulcrum of Whitehall Effectiveness	HC 1977
Twelfth Special Report	Government Response to the Committee’s Thirteenth report: A smaller House of Lords: The report of the Lord Speaker’s committee on the size of the House	HC 2005
Thirteenth Special Report	Government Response to the Committee’s Fourteenth Report: The Role of Parliament in the UK Constitution Interim Report The Status and Effect of Confidence Motions and the Fixed-term Parliaments Act 2011	HC 2065
Fourteenth Special Report	Government Response to the Committee’s Fifteenth Report: Status of Resolutions of the House of Commons	HC 2066