

# Memorandum to the Public Administration and Constitutional Affairs Committee by the Parliamentary and Health Service Ombudsman

Scrutiny inquiry 2020-21

29 October 2021

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## Summary

In the final year of PHSO's 2018-21 Corporate Strategy, we continued to deliver an effective service to the public and make key improvements in the face of the significant impact of the COVID-19 pandemic.

Despite the challenges presented by the pandemic, PHSO successfully progressed thousands of investigations, recruited and trained new caseworkers, and improved casework quality.

PHSO also successfully achieved key strategic milestones in 2020-21. These included a new digital publishing platform to bring greater transparency to PHSO's casework decisions, the launch of the new Complaint Standards for the NHS with early adopters and pilot sites, and the implementation of recommendations from the clinical advice review. Several strategic partnerships with other Ombudsman services and the administrative justice sector were also established.

Looking ahead, PHSO's draft Corporate Strategy for 2022-25 seeks to improve access to justice, further strengthen the quality and timeliness of PHSO's service, and increase PHSO's impact in using the learning from the complaints we handle to drive improvement in public services. Following positive feedback on the previous draft, we carried out further work on the strategy to reflect the developments of the past year. We are currently carrying out a further consultation exercise as a result.

In the longer term, PHSO could achieve an even greater impact, and provide greater access to justice, if Government brought forward legislation to establish a new Public Service Ombudsman with modernised powers, in line with the Venice Principles and the recommendation made by PACAC in June 2020 and January 2021 and by PACAC's predecessor Committees.

## 1. Introduction

### 1.1. PHSO's vision

To be an exemplary public services Ombudsman providing an independent, impartial, and fair complaints resolution service, while using our casework to help improve public services.

## **1.2. PHSO's role**

PHSO makes final decisions on complaints that have not been resolved by UK Government departments, the NHS in England, and some other UK public organisations. We do this impartially and independently of Government, holding public bodies to account. PHSO is not part of Government, the NHS in England, or a regulator. We are neither a consumer champion nor an advocacy service. We hold public bodies to account and speak truth to power.

## **1.3. How we work**

PHSO looks into complaints where an individual or group believes there has been injustice or hardship because an organisation has not acted properly or fairly or has provided a poor service and not put things right.

We expect people to complain to the NHS organisation or Government agency first, so it has a chance to put things right. If an individual believes there is still a dispute about the complaint after an organisation has responded, PHSO can be asked to consider it.

When we first receive a complaint, we make initial checks to see if we can deal with it. We confirm whether the complaint is within the powers of PHSO to investigate the organisation and issue complained about. We also check whether a complaint is ready for us to investigate. For example, complaints about Government departments and agencies must be referred to PHSO by an MP.

If a complaint moves past this stage, then we take a closer look to decide how best to resolve matters through a primary investigation. We consider whether the complaint can be resolved quickly, for example by reaching a shared agreement between the organisation and the complainant. If not, we examine the evidence available, alongside specialist advice if relevant, to decide if there are unresolved matters.

If a complaint cannot be decided following a primary investigation, PHSO will perform a more detailed investigation. A complaint is upheld if the organisation complained about got things wrong, the person was negatively affected, and the organisation has not already put things right. When a complaint is upheld, PHSO makes recommendations to the organisation complained about to rectify this.

PHSO shares findings from casework with Parliament to help it hold organisations that provide public services to account. We also share findings more widely to promote improvements in public services.

## **1.4. Data about PHSO's performance**

At the end of each financial year, we carry out checks on performance data to make sure it is accurate before we publish it in PHSO's annual report. As a result, the data that appears in the 2021-22 Annual Report when it is published in 2022 may differ slightly from 2021-22 data provided to the Committee before then.

## **2. Leading and improving PHSO**

When the COVID-19 pandemic arose in March 2020, PHSO rapidly adjusted ways of working and technology to enable the organisation to deliver a full range of services to the public while staff were working from home.

Throughout this period, PHSO faced the same challenges that affected other people and organisations across society, as staff juggled the caring responsibilities, illnesses and anxieties generated by the pandemic.

Notwithstanding these challenges, PHSO successfully delivered significant change in the final year of PHSO's 2018-21 Corporate Strategy.

We invested in additional IT equipment to support the rapid transition from office-based to remote working, and other equipment to ensure PHSO's offices were COVID-19 secure for staff who were not able to work from home, and to support a safe return to office-based working when that became possible.

We converted PHSO's entire training programme into e-learning, so that new caseworkers could be inducted and trained, and existing staff could continue their professional development while working remotely. PHSO delivered nearly 1,500 days of training to staff 2020-21. This is equivalent to more than three days training per person. Staff survey results from 2020 showed that 89% of staff felt they had the skills needed to do their job effectively.

We continued to focus on value for money, developing a sector-leading approach to measuring the value for money we provide. This approach has been highlighted by the National Audit Office as an example of good practice. The other two elements of our value for money framework are peer review and the HM Treasury value for money framework. We will undertake a peer review in the next period and are piloting use of the HM Treasury framework.

Following a one-year funding settlement for 2021-22, we postponed the launch of PHSO's next Corporate Strategy. We have instead used 2021-22 as a bridging year, to focus on recovering from the impacts of the pandemic, including piloting a hybrid model of remote and office-based working for PHSO staff.

We will launch PHSO's new strategy for 2022-25 later in the current business year. The new strategy will focus on improving access to PHSO's service, ensuring that people receive a high-quality service, and encouraging a culture of learning and continuous improvement in public services.

## **3. Operational performance and improvement**

### **3.1. Casework performance and impact**

COVID-19 has created very significant challenges for PHSO's service. Over an extended period, the NHS and Government departments struggled to contribute to PHSO's investigations and respond to PHSO's enquiries in a timely way, as they redirected resources to respond to the pandemic. In a number of areas, ongoing pressures mean delays in responding to our enquiries continue.

PHSO paused work on complaints about the NHS between 26 March and 30 June 2020 to allow the NHS to focus its resources on responding to the COVID-19 crisis. We took this decision after listening to advocacy groups and NHS organisations, and as we

learnt that complaints teams were increasingly being re-deployed to support the pandemic response. The NHS also paused all complaint handling during this period.

PHSO focused on maintaining a service to the public by keeping phone lines open and continuing to progress complaints about Government departments and agencies as far as possible. We were also able to continue some work on complaints about the NHS where we could make progress without needing to contact NHS organisations or staff.

Despite these significant challenges, PHSO made decisions on over 23,000 complaints including 4,421 following primary or detailed investigations, in addition to complaints that were completed following initial checks. This compares to 30,895 decisions made in 2019-20, 7,740 of which were primary or detailed investigations. We dealt with nearly 80,000 enquiries in 2020-21 and accepted nearly 25,000 complaints. PHSO made 745 recommendations including a total of nearly £500,000 in financial remedy to complainants who had been failed by public services.

By the end of 2020-21, the impact of the pandemic resulted in a queue of 3,084 complaints waiting to be investigated, and an increase in how long it took to close complaints. Since then, PHSO has focused on using 2021-22 as a period of recovery and stabilisation. We continue to recruit and train additional caseworkers. PHSO is also focusing on complaints that involve more serious injustices - an approach that is already routine for many Ombudsman services in other sectors and countries.

Even with the additional efforts of PHSO's recovery plan, we expect the next period to be increasingly difficult. The NHS continues to face significant challenges as it grapples with both the ongoing impact of the pandemic and large backlogs and waiting lists of people seeking to access care. Official figures show more than 5.6 million people are now waiting for NHS treatment, with potentially millions more who have faced delays to treatment and difficulties accessing care.<sup>1</sup> Other frontline public services face similar issues, with nearly half a million cases waiting to be heard in magistrates' courts, and the backlog of cases in the Crown Court reaching "crisis levels".<sup>2</sup> This will continue to affect how quickly organisations can provide information to enable PHSO to progress complaints. In turn, we expect this to affect the time it takes PHSO to reach a decision on complaints.

Early intelligence from frontline NHS organisations, along with a substantial increase in calls to PHSO's enquiry line, also suggests we will see a significant increase in the number and complexity of complaints PHSO receives about the NHS over the next period, as complaints about long waiting times and difficulties accessing NHS services flow through to PHSO. This is being compounded by a shift in the public's attitude towards the NHS, as patients and their families struggle with the reality of living in pain and illness due to delays in care and treatment, and become less forgiving of the NHS' difficulties in providing timely care as a result.

### **3.2. Improving PHSO's casework**

Despite the challenges presented by the pandemic, PHSO made further improvements to the quality of casework in 2020-21, including a new, sector-leading set of

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<sup>1</sup> BMA, [Pressure points in the NHS: July and August 2021 analysis](#), 2021.

<sup>2</sup> House of Lords Select Committee on the Constitution, [COVID-19 and the Courts, 22<sup>nd</sup> Report of Session 2019-21](#), 2021.

comprehensive quality standards. These standards are driving a focus on achieving consistently high-quality casework. Alongside the new standards, PHSO introduced improved guidance and training for caseworkers, as well as coaching and support from a team of casework quality experts.

PHSO continued with its accreditation programme for senior caseworkers, helping to professionalise complaint-handling and improve standards. In 2020-21, PHSO introduced a new process for re-accreditation, ensuring that accredited caseworkers continue to maintain and develop their skills.

PHSO continued to build on previous work to resolve more complaints earlier in the process without always needing to carry out a detailed investigation. During 2020-21 we resolved nearly 300 complaints with the agreement of the complainant, including 14 through mediation, which resulted in an outcome that all parties agreed to, despite limited availability of clinicians.

In one example, PHSO was able to achieve a financial remedy of at least £110,000 for a complainant who had been forced to pay this amount for care and support services due to a flawed decision by the NHS not to provide funding. PHSO's caseworker achieved this by drawing on evidence and using their specialist knowledge to work with the NHS without needing to carry out a detailed investigation. In another example, a complainant who had been a victim of identity theft was denied a new passport, which meant they had no photographic identification to open bank accounts, apply for jobs, or access benefits. It also meant they were unable to see their children or parents, who lived abroad. These issues had a significant impact on the complainant's mental health and financial security. By working with the complainant and the Home Office to reach a mutually agreed outcome, PHSO was able to resolve the complaint and ensure the complainant was issued with a new passport.

PHSO also made further progress in improving the way we commission and use advice from expert clinicians, following an independent review commissioned by PHSO in 2018. In 2020-21, we introduced significant changes to increase the involvement of clinical advisers in investigations. This included seeking clinical advice earlier in the investigation process and, for more complex investigations, an additional level of assurance from clinical advisers that their advice has been applied appropriately. To support the NHS to better understand how PHSO uses clinical advice to make judgements about the care and treatment they provide, we issued case studies that illustrate how PHSO applies its clinical standards when we investigate complaints.

## **4. Sharing good practice and insight**

### **4.1. Engaging externally**

Throughout 2020-21, PHSO worked closely with other Ombudsman services, researchers, and academics to challenge and support public services to learn from complaints. For example, PHSO initiated and led a research project with the International Ombudsman Institute to examine the impact of the COVID-19 pandemic on Ombudsman services and share good practice in managing that impact. An interim

report published on Ombuds Day 2020<sup>3</sup>, followed by a final report in May 2021, shared the learning from 53 Ombudsman services across 37 different countries.<sup>4</sup>

In spring 2021, PHSO launched a partnership with the South African Office of the Health Ombud (OHO), supported by the UK Foreign and Commonwealth Development Office. The partnership aims to bring mutual benefits to both PHSO and OHO. We have held four virtual learning exchanges so far, covering casework methodology, mediation and resolution, and peer review.

PHSO is also an active contributor to the administrative justice sector's work to examine the learning from failings made by the Windrush Compensation Scheme. This work seeks to ensure the complaints process is efficient and fair, and that people affected by Windrush receive timely decisions on their applications for compensation.

The Radio Ombudsman podcast series continued during the COVID-19 pandemic, with guest appearances in 2020-21 from experts including Baroness Hale, former President of the Supreme Court; Lord Adebowale, Chair of NHS Confederation; and Sir Robert Francis, Chair of Healthwatch England.

## 4.2. Sharing the learning from complaints

In 2020-21, PHSO progressed plans to publish more casework decisions online. This was a significant digital transformation project that required a new online publishing system to be built, as well as changes to PHSO's casework processes to protect the privacy of complainants. The new digital publishing platform was launched in early 2021-22 and we will develop the platform over the next period to share more information about our casework and ensure it is as accessible as possible to use.

In July 2020, PHSO published *Making Complaints Count*, a major report that examined the quality of complaint handling across the NHS in England and UK Government departments.<sup>5</sup> We found that the current complaints system was not meeting the needs of the public, due to inconsistency in the way complaints are handled by frontline public services and cultural barriers that mean public bodies often fail to see complaints as a positive source of learning to help improve their services. The learning from this report has informed PHSO's work to drive up the quality of frontline complaint-handling in public services and to develop a set of Complaint Standards for the NHS.

In November 2020, PHSO published *Continuing Healthcare: Getting it right first time*.<sup>6</sup> The report identified the learning from complaints about a type of NHS-funded care called continuing healthcare (CHC). We found that delays and incorrect decisions meant that people with complex care needs were forced either to go without the essential care they needed, or to pay hundreds of thousands of pounds for privately funded care that should have been funded by the NHS. PHSO recommended that NHS staff be supported with clearer guidance, training and coaching to improve the quality and timeliness of decisions about CHC. In summer 2021, PHSO wrote to the Chair of PACAC to welcome the progress that has been made in meeting these

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<sup>3</sup> [The Ombudsman, coronavirus and crisis management, 2020.](#)

<sup>4</sup> [The Art of the Ombudsman: leadership through International Crisis, 2021.](#)

<sup>5</sup> [Making Complaints Count: Supporting complaints handling in the NHS and UK Government Departments, 2020.](#)

<sup>6</sup> [Continuing Healthcare: Getting it right first time, 2020.](#)

recommendations, while also highlighting concerns that the reforms set out in the current Health and Social Care Bill, which will transfer responsibility for CHC to new NHS bodies, risk repeating the mistakes that followed the previous set of NHS reforms in 2012.

Alongside these major reports, in 2020-21 PHSO also responded to several consultations, include one from the Ministry of Justice on improving the Victims' Code. In PHSO's submission, we recommended that the 'MP filter' be removed, so that complainants could choose whether or not to refer a complaint to their MP before bringing it to PHSO.

We contributed to the independent review of maternity services at Shrewsbury and Telford NHS Trust by sharing the learning from PHSO's investigations, and we submitted evidence to PACAC regarding the potential scope of the forthcoming public inquiry into the Government's response to the COVID-19 pandemic. We highlighted the importance of learning from complaints and examining the way a wide range of public services responded to the pandemic.

More recently, PHSO has published complaints about the communication of changes to women's State Pension Age, the care and treatment of a baby who died in hospital, HS2's failure to communicate with a family over the sale of their home, and UK Visas and Immigration's handling of the immigration status of a man from the Windrush generation. We have also published a major report on the learning from failings in the way the NHS requests, reports and acts on x-rays, CTs and other scans.<sup>7</sup> We have recommenced publication of statistical data about the complaints we receive after reviewing how we can publish this information in a way that best meets the needs of the people and organisations who use it.

#### **4.3. Improving the quality of frontline complaint-handling**

PHSO led the creation of new Complaint Standards for the NHS in England, following extensive engagement with NHS organisations, patient advocacy groups, and the public. The Complaint Standards were launched in March 2021 and PHSO is working with 11 NHS bodies, representing different healthcare sectors, to pilot the Standards before wider implementation throughout the NHS in England.<sup>8</sup> A further 69 NHS bodies are following a self-directed process as early adopters of the NHS Complaint Standards.

PHSO is now working with Government departments and agencies to develop a similar set of Complaint Standards, to improve the quality and consistency of frontline complaints-handling.

## **5. Improving PHSO's impact**

A modern Ombudsman service with updated powers is essential, not only to improve access to justice, but also to ensure public services are supported and challenged to learn from the COVID-19 pandemic.

PHSO's work achieves resolution for thousands of individuals and families who use PHSO's service every year, and it also helps drive improvement in the quality of public services for everyone. Through PHSO's work with PACAC, other Select

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<sup>7</sup> [Unlocking Solutions in Imaging: working together to learn from failings in the NHS, 2021.](#)

<sup>8</sup> [NHS Complaint Standards.](#)

Committees and independent inquiries, we also support the scrutiny of Government and the NHS and help hold public services to account.

PHSO's impact could be far greater, however, if the outdated legislation that governs our work was reformed. This much-needed reform was recommended by PACAC in July 2020 and January 2021, as well as by PACAC's predecessor committees. Similarly, the 2018 independent review of PHSO's value-for-money found that "PHSO is now out of line with other UK public services Ombudsman offices and wider international practice".<sup>9</sup> Reforming the Ombudsman would enable "more effective access to justice for all citizens and seek to improve public service delivery".

PHSO's outdated powers put the UK and England out of step with international benchmarks of good practice, as defined in the *Venice Principles on the Protection and Promotion of the Ombudsman Institution*.<sup>10</sup> The UK Government itself co-sponsored the adoption of these *Venice Principles* by the United Nations. Despite this, the Government has confirmed to PACAC that "there is no active work in Government" to explore Ombudsman reform.<sup>11</sup>

PHSO continues to seek opportunities in relevant legislation that is already planned during the current Parliamentary session, for a small number of significant but straightforward amendments to support these reforms.

PHSO works closely with the Local Government and Social Care Ombudsman (LGSCO), including through a joint working team that considers complaints about health and social care that cut across the different jurisdictions of PHSO and LGSCO. A much more streamlined service, with a single Public Service Ombudsman, would remove the need for such workarounds and make it easier for members of the public to know where to turn when they have been let down by public services.

While the Complaint Standards for the NHS and for Government departments will help to improve the quality of complaint-handling in public services, PHSO's ability to influence this improvement is limited by the absence of modernised statutory powers. Unlike the Scottish Public Service Ombudsman, we do not have the power of a 'Complaint Standards Authority' to set the standards for complaints-handling. Such powers would allow us to take action where public services are not meeting relevant standards and choose not to adopt the Standards on a voluntary basis. These powers could be introduced for complaints about the NHS in England through an amendment to the Health and Social Care Bill.

Access to justice would also be improved by removing the outdated 'MP filter'. Currently, members of the public are prevented from bringing a complaint about a UK Government department or agency to PHSO unless it is referred to us by an MP. MPs play a vital role in supporting constituents to resolve their concerns and removing the filter would not stop them from being able to refer their constituents' complaints to us. It is simply not right, however, that if a citizen does not wish to approach their MP for any reason, they are effectively barred from accessing justice via the Ombudsman.

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<sup>9</sup> [Value for Money Study: Report of the independent peer review of the Parliamentary and Health Service Ombudsman \(2018\)](#)

<sup>10</sup> [Principles on the Protection and Promotion of the Ombudsman Institution \("The Venice Principles"\), 2019.](#)

<sup>11</sup> [Letter from Rt Hon Michael Gove MP to Mr William Wragg MP, 9 Sept 2020.](#)



Removing the ‘MP filter’ could also enable democratically-elected representatives in the three devolved legislatures in Wales, Scotland, and Northern Ireland to refer a complaint to PHSO on behalf of their constituents - something they are currently barred from doing, despite PHSO being the Ombudsman service for the whole of the UK. Amendments to current and planned legislation, such as the forthcoming Victims Bill, could make progress towards this goal and open up access to justice.

Unlike Ombudsman institutions in Wales and Northern Ireland, PHSO does not have the power of ‘own initiative’. This means we are unable to look at the injustice or hardship faced by people who are unable or unwilling to complain, such as people who are long-term inpatients in mental health and learning disability services, where they may fear their care and treatment will be adversely affected if they make a complaint. This leaves people who are in vulnerable circumstances without the opportunity to achieve justice if they have been let down by the public services they should be able to rely on.

PHSO has a unique constitutional role providing an independent and impartial service to the public, as well as supporting the scrutiny of public services. The current legal framework, which dates from as far back as 1967, limits PHSO’s impact and impedes access to justice for those who most need it. Fundamental reform is now urgent.

#### **Appendices:**

- A. Recent feedback from complainants<sup>12</sup>
- B. PHSO’s performance against the Service Charter
- C. Staff survey results 2020

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<sup>12</sup> We have included a selection of positive feedback to give balance for the Committee, who might otherwise only see feedback from the regular contributors to PACAC scrutiny inquiries, that is generally more negative in nature.

## Appendix A: Recent feedback from complainants

In 2020-21 PHSO recorded 100 pieces of positive feedback about our service. This is broadly in line with volumes in previous years, but set against the additional challenges of the disruption to services caused by the pandemic. This is a small sample of some of the feedback received.

### January 2021

*'Thank you for taking the time to consider our case. I'd also like to say thank you for showing us so much respect. You feel like the first human being we have dealt with and you express such a warm tone. It's comforting and it is appreciated.'*

**Feedback from a complainant about a Caseworker**

### November 2020

*'I want to thank you, you have been really good and I have no criticism whatsoever. You enabled me to fully participate in your service. Although it has not worked out how I would have liked I am very grateful'*

**Feedback from a complainant about a Caseworker**

*'Whilst we are obviously disappointed with the outcome, we thank you very much for your help and support in raising our concerns. At least now we have closure and we are very grateful for that'*

**Feedback from two complainants about a Caseworker**

### August 2020

*'Thank you so much for all of your work on our case. We greatly appreciate the work that you have put into it, for listening to our grievances throughout the process and for following up and taking these to [the organisation]. It feels like it's been a battle for us, but it is encouraging that, with a little bit of patience and perseverance, even where there are shortfalls in the system it is still possible to redress these wrongs and achieve some form of justice. We're really grateful for the important role that people such as yourself play in safeguarding this. ...As such, we want to, one last time, express our sincere gratitude to you, personally, and to PHSO.'*

**Feedback from two complainants about a Senior Caseworker**

*'[We] would like to thank you for your diligence in dealing with the complaint. ...I feel as though I have been listened to and not fobbed off due to my mental health issues. I hope it makes them think before they do the same to other people and stops other families going through the hell that we have.'*

**Feedback from two complainants about a Caseworker**

## Appendix B: PHSO’s performance against the Service Charter

PHSO’s Service Charter<sup>13</sup> makes commitments about the service we provide throughout the different stages of PHSO’s process. We use these commitments to seek feedback on how well we are delivering our service and understand where we need to improve.

We developed the Service Charter with people who have used PHSO’s service and the organisations we investigate and work with, to find out what matters to them.

We collect and publish feedback from complainants to provide a better view of our service from those who use it. We use an independent research agency to collect and collate feedback from complainants and organisations we investigate. We are currently the only UK public service Ombudsman that carries out regular surveys of this nature.<sup>14</sup>

Commitment 10 of the Service Charter includes a commitment to provide an impartial service: “We will evaluate the information we’ve gathered and make an impartial decision on your complaint”. Following a previous recommendation from PACAC, however, we asked an independent research agency to look at how we could measure impartiality. The research company recommended that PHSO should measure impartiality using an aggregate of the feedback received on Service Charter commitments 5, 8, 9, and 11, supported by qualitative research with complainants through, for example, focus groups.<sup>15</sup> This approach was adopted in 2020-21 onwards, which is why no score is available for commitment 10 in previous years.

Commitment	2020-21	2019-20	2018-19
<i>Giving you the information you need</i>			
1. We will explain our role and what we can and cannot do	77%	79%	79%
2. We will explain how we handle complaints and what information we need from you	78%	79%	80%
3. We will direct you to someone who can help with your complaint if we are unable to, where possible	76%	72%	78%
4. We will keep you regularly updated on our progress with your complaint	80%	79%	81%

<sup>13</sup> PHSO’s Service Charter is published in full on our website: <https://www.ombudsman.org.uk/making-complaint/how-we-deal-complaints/our-service-charter>

<sup>14</sup> This means there is no standard benchmark or UK public service Ombudsman against which to compare the results of our Service Charter surveys.

<sup>15</sup> More information about this research is published on PHSO’s website: <https://www.ombudsman.org.uk/about-us/corporate-information/how-we-are-performing/performance-against-our-service-charter/research-fairness-and-impartiality>

<b>Overall feedback score for this section</b>	<b>78%</b>	<b>77%</b>	<b>79%</b>
<b>Target score</b>	<b>84%</b>	<b>84%</b>	<b>75%</b>
<b><i>Following an open and fair process</i></b>			
5. We will listen to you to make sure we understand your complaint	71%	72%	73%
6. We will explain the specific concerns we will be looking into	81%	87%	88%
7. We will explain how we will do our work	77%	77%	77%
8. We will gather all the information we need, including from you and the organisation you have complained about before we make our decision	51%	51%	48%
9. We will share facts with you, and discuss with you what we are seeing	69%	70%	68%
10. We will evaluate the information we've gathered and make an impartial decision on your complaint <sup>16</sup>	73%	-	-
11. We will explain our decision and recommendations, and how we reached them	49%	47%	53%
<b>Overall feedback score for this section</b>	<b>66%</b>	<b>67%</b>	<b>68%</b>
<b>Target score</b>	<b>70%</b>	<b>69%</b>	<b>65%</b>
<b><i>Giving you a good service</i></b>			
12. We will treat you with courtesy and respect	87%	89%	90%
13. We will give you a final decision on your complaint as soon as we can	46%	50%	53%
14. We will make sure our service is easily accessible to you and give you support and help if you need it	62%	65%	67%
<b>Overall feedback score for this section</b>	<b>65%</b>	<b>68%</b>	<b>70%</b>
<b>Target score</b>	<b>70%</b>	<b>71%</b>	<b>67%</b>

<sup>16</sup> Service Charter commitment 10 is calculated in a different way to the other Service Charter commitments, as described on the previous page.

## Appendix C: Staff survey results 2020

Engagement index	My work	Organisational objectives	My manager	My team
<b>66</b> <b>Comparison</b> CSPA 2020: +/-0 Staff Survey 2019: +1	<b>76</b> <b>Comparison</b> CSPA 2020: -4 Staff Survey 2019: -1	<b>78</b> <b>Comparison</b> CSPA 2020: -7 Staff Survey 2019: -7	<b>78</b> <b>Comparison</b> CSPA 2020: +4 Staff Survey 2019: -2	<b>80</b> <b>Comparison</b> CSPA 2020: -4 Staff Survey 2019: -5
Learning and development*	Inclusion and fair treatment	Resources and workload	Pay and benefits	Leadership and managing change**
<b>62</b> <b>Comparison</b> CSPA 2020: +6 Staff Survey 2019: +17	<b>74</b> <b>Comparison</b> CSPA 2020: -8 Staff Survey 2019: -6	<b>66</b> <b>Comparison</b> CSPA 2020: -9 Staff Survey 2019: -7	<b>69</b> <b>Comparison</b> CSPA 2020: +29 Staff Survey 2019: +11	<b>61</b> <b>Comparison</b> CSPA 2020: +3 Staff Survey 2019: +7

I believe that the Ombudsman and CEO have a clear vision for the future of PHSO	33%	49%	12%	82%	5	22
The Ombudsman and CEO are sufficiently visible**	33%	54%	7%5%	87%	N/A	N/A

The headline scores are calculated by applying a weighting to each response on the 5-point agreement scale (strongly agree=100, agree=75, neither=50, disagree=25, strongly disagree=0). This approach means that a score of 100 is equivalent to all respondents saying strongly agree to all questions in that theme, while a score of 0 is equivalent to all respondents saying strongly disagree to all questions.

CSPA = Civil Service People Survey

\*Note: a question has been amended in 2020. Therefore, direct comparisons with previous scores and the CSPA should be treated with caution.

\*\*Leadership and managing change takes into account more questions than previous years. Therefore, direct comparisons with previous scores and the CSPA should be treated with caution.

\*\*New questions added for 2020 do not have comparator scores in CSPA or previous surveys.