**Guide to what happens when a complaint comes to PHSO**

The below is a summary of key, relevant aspects of the approach we take to decide how best to handle a complaint. It is not designed to be an exhaustive list of the processes that come under our Service Model.

Some of these aspects are given under our legislation, whilst others refer to the broad discretion PHSO has when considering whether to investigate a complaint.

There’s more information on our website that sets out our procedures [How we deal with complaints | Parliamentary and Health Service Ombudsman (PHSO)](https://www.ombudsman.org.uk/making-complaint/how-we-deal-complaints).

We’d be happy to talk in more detail about our casework process to you and your colleagues if that would help.

**UKCG** = UK Central Government Departments and its agencies (and other public bodies)

| **Approach**  | **Notes** | **Other factors**  |
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| **Step 1** |
| Is it a ‘properly made’ complaint? | Under our legislation a complaint must be made in writing. | PHSO treats complaints made by email or via its online complaint form as being in writing. |
| If the complaint is about UKCG, it must be referred to PHSO by a Member of Parliament.  | This does not have to be the complainant’s local MP, although this is usually the case. |
| Is the complaint being made by someone other than the person affected? | Legislation says that the person affected must make the complaint themselves unless there is any reason they are unable to do so. This is usually if they are deceased, or otherwise incapable of bringing the complaint themselves.A complainant can also choose somebody to represent them, but there must be clear and express consent for that. PHSO will also assess whether the representative is suitable to represent the complainant.  | Where a representative is involved, PHSO would also need to see consent from the complainant to refer his/her complaint to an MP for the purposes of referring to PHSO.  |
| Has the complaint been through the organisation’s own complaints process already? | Overall, PHSO would need to see that the organisation to be aware of the complaint and have the opportunity to formally respond/resolve the cases. PHSO has discretion to look at a case if local process has not been used or exhausted if:* PHSO believes it was not reasonable to expect the complainant to do so;
* PHSO is satisfied that the local process has come to an end; or
* There is an exceptional reason (see right)

For UKCG complaints, this would include any independent tier stages the organisation has in place.  | PHSO may look at whether there are exceptional circumstances. These could cover (but are not limited to) the following:* Complainant is suffering particular difficulties that may be linked to the issue in question (e.g. extreme hardship)
* There is a time specific issue (e.g. terminal illness);
* It is clear the relationship between complainant and organisation has broken down completely.

PHSO may also decide to use its discretion to look further at a case if:* The case relates to an issue PHSO considers could relate to a wider/systemic issue and where PHSO believes its work could add value for a larger group of people; and/or
* The issues raise significant or serious issues.
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| **Step 2**  |
| Has the complaint been made ‘in time’? | Under PHSO legislation, for health complaints, complainants must refer their complaint to PHSO within one year from the day they first became aware of the reason to complain. For UKCG complaints, complainants must refer the matter to an MP within one year from the day they first became aware.PHSO can use discretion if it sees reasonable cause for why the complainant did not refer their complaint within one year.  | PHSO recognises that, on occasion, the date the complainant became aware of the reason to complain is not always the same as the date the incident occurred. PHSO will look at the reasons for any delay on a case-by-case basis. This can include how long it has taken for the organisation to respond locally, as well as any exceptional circumstances. |
| Does the complainant have an alternative legal route? | Under legislation, PHSO cannot investigate if there is or was a legal remedy that the complainant could take (or could have taken), unless it is (or was) not reasonable for them to do so.Legal remedies can include established methods for challenging a decision (including Judicial Review). | PHSO will seek information about the issues in hand in order to examine whether a remedy to this could be achieved via a legal route.  |
| Are there indications that poor administration or service failure has occurred?Has that potentially led to a negative impact for the person affected, which has not yet been put right?  | There is no definition of maladministration or service failure. PHSO’s Principles of Good Administration highlight the general expectations for public service organisations within PHSO’s remit. PHSO will normally look at what happened compared with what should have happened, using any relevant standards to determine that.  | PHSO will need to see indications that there is a potential fault or service failure.PHSO will also consider whether and potential fault, mistake or service failure has led to a negative impact on the individual, which has not yet been put right.   |
| Other factors to consider | PHSO will also look at whether:* The outcome sought by the complainant is not reasonable or achievable
* If an investigation would not be practical (for example it would not be able to reach a satisfactory conclusion)
* Another organisation is considering the same issues (e.g. coroners court)
* the seriousness of the potential negative impact warrants a detailed investigation.
 | In April 2021, we made changes to our service so that we only look further into more serious complaints about the NHS that people bring to us.As a general guide, PHSO is more likely to investigate:* Cases where there are indications that a significant and serious service failure has occurred, or where there is potential significant injustice or harm (for example, a potentially avoidable death).
* Where there is a wider public interest. This could include where we have identified a systemic issue with an organisation’s process, or where it is possible that a large number of people have been affected.
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