Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Cyllid ar Adolygiad o weithrediadau, prosesau ac ymchwiliadau Ombwdsmon Gwasanaethau Cyhoeddus Cymru.

This response was submitted to the Finance Committee consultation on the Review into the operations, processes and investigations carried out by the Public Services Ombudsman for Wales.

PPSOWA9: Ymateb gan: Nick Bennett (Cyn Ombwdsmon Gwasanaethau Cyhoeddus Cymru) | Response from: Nick Bennett (Former Public Services Ombudsman for Wales)

WITNESS STATEMENT OF NICK BENNETT

1. I make this statement in response to the Senedd' Finance Committee's Consultation request for evidence to inform its review of the Public Services Ombudsman (Wales) Act 2019 ("the Act"). I do so in my capacity as former Ombudsman - an office I held from 2014 – 2022. Accordingly, I was in post at the time the Act became law (in May 2019).

Background

2. In 2015, I submitted evidence to the Committee in support of the case for change and provision of new powers by seeking changes in the areas below:

(a) To enable me to undertake Own Initiative investigations (OIs)
(b) To remove the legal requirement for complaints to be in writing
(c) To streamline and improve complaint handling across the public sector by establishing a Complaints Standards Authority (CSA)
(d) To extend my powers to allow me to investigate certain aspects of private healthcare
(e) To improve links with the courts and enable me to refer legal points for determination by a court where that would assist my investigation.

3. I remain extremely pleased that the Committee agreed and implemented all but one (the link with courts) of the above powers within the new Act. This has, in my view, enabled Wales to stay ahead of most of the UK Ombudsmen in having a modern Act fit for the 21st century and it is future proofed in most areas. I will say more about this comparison with other jurisdictions later. I will briefly focus on each of the powers above in relation to the Committee's Terms of Reference for this review.

Operation and effectiveness of the Act / public confidence

4. I think it is better for my successor to primarily address this overall given my tenure ended in March 2022, as she will be better placed to give a more meaningful view of the entire period. What I do know is that the pandemic impacted progress during the initial period after powers were granted (see below). Nevertheless, public access to the Ombudsman has been increased and I know that my successor will demonstrate increased public confidence, for example, from the Black Minority Ethnic (BME) community.

Oral complaints

5. With the advent of technology, and to provide a right to vulnerable citizens (particularly those who have difficulties with the written word) to bring their

complaint directly to an Ombudsman by presenting it orally, this new power has proven itself to be absolutely necessary. Whilst I always had the discretion to accept complaints orally, this was usually exercised only for equality reasons, and exceptionally, given the specific requirement for writing under the old legislation. It remains the case that complaints about elected members having breached the Code of Conduct are made in writing as the Act does not cover that complaints regime.

6. Whilst this has increased the workload to my office, the advantages and benefit to complainants cannot be underestimated. Many complainants, whilst able to write, do lack the confidence in their written skills to present written complaints effectively and may not have approached the office in the past. This power was also impacted by the COVID-19 pandemic given staff had to work from home and we were not able to immediately upgrade our telephone system to enable full telephone access at home. Messages had to be left on answerphones and call backs arranged, meaning the process was initially slower, however a service was being provided.

7. The ability to take complaints other than in writing has, without doubt, considerably increased accessibility to the Ombudsman. Since the power was granted in 2019 to March 2022 (the end of my tenure) the office had recorded taking 332 complaints other than in writing. I believe that many of those people would not have accessed the service when they did - if ever - so greatly improving public access to the office.

Own Initiative (OI) investigations and protecting the vulnerable

8. A number of extended OI investigations have been undertaken in regular casework. This has enabled some complainants to have wider issues explored than those initially complained about – something not previously possible under the constraints of the old legislation. In the first year of being granted these new powers we had commenced four such investigations (Annual report 2020/2021).[1] The Act also gave me the power to undertake wider OIs, the first of which was completed during my tenure and I will refer to later.

9. The first significant case using the extended OI power related to a complainant who had come to me complaining about delays in his prostate cancer care. The delays were such that he had ultimately paid for part of his own treatment. Apart from uncovering failings in his care, information provided during the investigation led me to consider that there had been

[1] Delivering Justice

delays in other cases. Even though those individuals had not complained to me, I extended the investigation to consider the wider aspect of prostate cancer delays at the Health Board concerned. The investigation uncovered delays and potential impact to 16 other patients within the same period. Furthermore, in the case of half of those, the Health Board had not undertaken any reviews to assess whether the delays had caused those patients harm (simply because they had later been referred for treatment to England under local commissioning arrangements). This would not have been unearthed unless those individuals had all made direct complaints to me and was only possible to pursue because of the extended OI power. I was able to recommend that the Health Board undertook reviews into potential harm caused to those patients under the "Putting Things Right" NHS complaints process, and offer any individual redress, as appropriate.

10. The first wider OI was launched in early 2020 with a consultation (closing date of 10 April 2020) on the suggested service failure or maladministration in the field of homelessness (homelessness assessments and reviews in particular). I selected this given some compelling evidence already provided to me by the third sector, and as homeless people are amongst the most vulnerable – and voiceless - in our society. However, in March 2020, shortly before I could properly start my investigation, the COVID-19 pandemic struck. Being mindful of the pressure on public services, and the urgent action taken to try to temporarily house all street homeless people to protect them from the COVID-19 virus, I felt it appropriate to suspend the OI. It was better to focus and try as best as we could to continue with the individual investigations from our regular complaints and continue to provide access to my service during challenging times. I am proud that the office did so.

11. When revisiting the investigation later in October 2020, I re-consulted on it adding a further strand to my original proposal in order to consider whether the actions taken during the pandemic, to assess and review the needs of homeless people, could provide opportunities for longer term or wider improvements. Therefore, the investigation itself only properly began on 20 November 2020 against 3 named local authorities. I will comment further on how I think such delays may be avoided in future.

12. My findings were finally issued on 29 September 2021.[2] I found that work undertaken by local authority Homelessness Teams during the pandemic crisis had often been exemplary. In considering practices before that, I found that often there had been no clear evidence in assessment or reviews of proper regard being given to both human rights or equality matters, as well as

[2] https://www.ombudsman.wales/wp-content/uploads/2021/10/Executive-Summary-Homelessness-Reviewed.pdf

matters being missed during an assessment. There were also delays in the process as well as an evident failure to provide support to vulnerable people or those with complex needs. I made several recommendations to the 3 authorities under investigation (as the Act only enabled me to make formal recommendations to bodies I investigated). As a report issued in the public domain, I was hopeful of other authorities taking note and electing to implement the recommendations too and expressly invited them to do so. I also identified instances of good practice and highlighting this in the report enabled the sharing of this with other authorities throughout Wales.

13. Two years after the publication of the OI report, my successor published a follow up report after a review of how the OI recommendations had been met. It was pleasing to see that the majority of Welsh local authorities had implemented the recommendations directed at the 3 authorities under investigation, that there was greater collaboration with third sector organisations and that the Welsh Government had itself built the findings of the OI investigation into its Ending Homelessness Action Plan. In my view, this shows the benefit of the wider OI investigation in highlighting issues and in enabling wide scale improvement throughout Wales. It was always envisaged that the power would be used sparingly but the outcome benefits are far reaching.

14. Before my term of office ended, another wider OI was being considered in relation to carers' needs assessments – another vulnerable group whose voices are often unheard. I understand that it was concluded on 17 October 2024 and so I shall leave it to my successor to expand on its findings and value as an OI, as appropriate.

15. As noted above, the first OI suffered a delay in its commencement in part due to the pandemic. There was also a delay due to the advance consultation required under s66 of the Act. I know from the discussions at the time, that the additional consultation requirements were felt necessary to provide safeguards against any perceived misuse of the OI power and/or potential overlap with work of other regulatory bodies. I believe, however, that the office has demonstrated that the power has not been over used and that it has been used wisely. The delays caused by the consultation process has been a source of frustration in preventing the office being able to progress an OI more swiftly. I believe that greater accessibility to justice could be achieved if the advance consultation requirement were removed, and that the OI power was aligned with the more streamlined and efficient power available to the Northern Ireland Ombudsman (of only consulting the relevant body proposed to be investigated).

Private healthcare

16. When arguing for this power I was struck by being unable to provide justice to a complainant whose health journey had been a combination of both NHS and private healthcare (see my evidence to the Committee in 2015). Whilst I understand that, to date, it remains the case that there has been no investigation using these powers, I firmly believe that this power should remain available for future use, if the need arose. This is to ensure that the Act and the Ombudsman's powers are future proofed. With increasing pressures on the NHS in Wales, more services are being commissioned in the private sector to meet need and more individuals are paying for some elements of care themselves when facing lengthy waits for treatment in some instances. As a result, the scenario I initially faced where I was powerless to assist the individual where there had been a combination of NHS and private care, could prove more likely to arise in future.

Complaints handling and the CSA

17. The aim of the CSA was to work with all public bodies in my jurisdiction to drive up improvement through supporting effective complaint handling and deliver bespoke training packages, and to collect and publish complaint data. It is fair to say that the CSA "hit the ground running" and, for example, despite the pandemic, in its first year adapted to deliver 90 virtual training courses to public bodies -primarily local authorities (Annual Report 2020/2021).[3] The following year (which was the last of my tenure – 2021/2022)) saw a total of 140 virtual training courses delivered, 39 bodies brought under the CSA and our first set of CSA data published.[4] I know that this has improved complaint handling practice across Wales. The number of complaints to the office against local authorities has increased since the implementation of the CSA, but this is largely because local authorities are now properly recording some contacts as complaints whereas in the past they were not.

18. Whilst the CSA has delivered training to NHS bodies in Wales, those organisations have their own separate NHS complaints regime (Putting Things Right). The model complaints policy is closely aligned with it, making direct comparison across the board with local authorities possible. I am sure that my successor will expand and provide more recent information about the CSA's work.

[3] Delivering Justice
[4] 2021-22-ANNUAL-REPORT-2021-22-EXECUTIVE-SUMMARY.pdf

The Act's objectives and its comparison with other legislation and practice

19. In my view, the Act and its extended powers has met its objectives. At the time of its introduction, I said that it was my hope that the new powers would give a voice to the voiceless, and I believe this has been the case. The use of the wider OI powers are clear examples. There has been greater access to the Ombudsman service, and more powerful investigations undertaken through the use of extended and wider OI investigations. For example, there is no more marginal a group than homeless people and the wider OI has secured improved practice Wales wide. It is also the case that Wales compares very favourably with other UK Ombudsmen jurisdictions for the following reasons. It is only the Northern Ireland Ombudsman which could be said to be a little ahead in the approach (for the reason I set out in paragraph 15 above).

20. The Ombudsman's offices in England and Scotland[5] still require all complaints to be made in writing. In England there is also a requirement for some complaints to be made via a Member of Parliament, providing citizens wishing to take their concerns further with no direct access to do so.[6] Neither country has OI investigation powers. Other countries are looking to Wales as a leading example and seeking the enhancement of their powers to match ours.

21. The only Ombudsman having OI powers is the Northern Ireland office, having held them since 2018.[7] Like Wales, it has used that power sparingly and only where appropriate. It has undertaken just 8 OI investigations in the last 5 years (3 on topics not within our jurisdiction in Wales – e.g. practices in Schools / Benefit payments). As noted above, the legislation in Northern Ireland enables a more streamlined process, and goes some way to explain why Wales has overall undertaken slightly fewer OIs in number, as well as the pandemic impact I commented upon earlier.

[5] Offices of the Parliamentary and Health Service Ombudsman (OPHSO) and Local Government and Social Care Ombudsman cover what is dealt with by the single Ombudsman office in Wales. The Scottish Public Services Ombudsman is a single office as in Wales.
[6] Requirements for OPHSO complaints
[7] Public Services Ombudsman Act (Northern Ireland) 2016 with OI powers in force from 1 April 2018

Costs and benefits of the Act / value for money

22. At the outset (see paragraph 2 above), when seeking additional powers, I provided full costings reflecting the budget increase I felt was necessary in order for the office to deliver on the extension in powers. The final total would be dependent on the actual powers granted to me – for example no power was granted for the links and referral to courts, as I sought. I was pleased to be granted what I requested and pleased that oral complaints have increased public accessibility I also think the office, for its relatively small size, delivers quality work and outcomes for the citizens of Wales..

23. In conclusion, I am proud that Wales continues to lead the way in Ombudsman jurisdictions across the UK and therefore I am grateful that the Senedd agreed to implement the new Act to enable the improvements I have addressed above.

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Nick Bennett

Public Services Ombudsman for Wales 2014 – 2022 .