Ombudsman

PUBLIC SERVICES OMBUDSMAN FOR WALES

IMPROVING ACCESS: DELIVERING IMPROVEMENT

ANNUAL **REPORT** 2011/12

The Annual Report 2011/12

of

The Public Services Ombudsman for Wales

Laid before the National Assembly for Wales
under paragraph 14 of Schedule 1
of the Public Services Ombudsman (Wales) Act 2005

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

1. Introduction

I am pleased to introduce this, my fourth, annual report since taking up my post as Ombudsman (and the sixth annual report of the Public Services Ombudsman for Wales following the introduction of the office in 2006).

The theme for this year's annual report is 'Improving Access: Delivering Improvement'. This recognises the work done to improve access to the complaints procedures of bodies within my jurisdiction, other public service providers, ombudsmen services (including my own service) and other complaint handling schemes. This has been done by raising awareness, making access easier for people with protected characteristics and through the Complaints Wales signposting service we have provided more information on how people can access advice and advocacy services to help them in making their complaints.

Delivering improvement reflects our work in improving public service delivery in Wales, by ensuring that the recommendations in my investigation reports are complied with, working with regulators to ensure that the changes introduced are sustained and effective, and working to share the lessons from those investigations with other public service providers.

The year 2011/12 was the final year of my three year Strategic Plan. The achievements against that Plan have been substantial. As well as achieving the objectives set there have been other key achievements that were unforeseen at the time of its initial development. Not least of these was the creation of the Complaints Wales service. This innovative telephone and web service provides advice to those members of the public who wish to complain about a public service but do not know how to do so. I talk about this in greater detail later in this report, however, I am particularly pleased that as far as the international community of ombudsmen is concerned, we in Wales appear to be a world leader in offering such a service and many others are now contemplating going down the same road.

With regard to our core activity, the complaints I receive about public services continue to rise, being 13% up on the number received during 2010/11. The NHS Redress Measure was introduced on 1 April 2011 and whilst this can account for some of this increase, it is only one factor. Concerningly, code of conduct complaints rose by 49% and I address this at Section 4 of this report.

We have over the past three years made great strides in improving efficiency in the way we consider complaints. In particular, I am pleased that although there has been a significant increase in the enquiries and complaints that we receive, we have still managed to exceed our performance targets. We also upgraded our complaints handling system during the course of the year with a view to getting new technology to take some of the strain of some of the administrative tasks associated with

complaint handling. I will over this next year be looking to see what more we might be able to do to improve efficiency. However, I am conscious that there is only so much that we can do in terms of increasing productivity and streamlining our ways of working before the robustness and quality of work is threatened.

During the past year, with the involvement of all my staff, I also produced my Strategic Plan for the next three years. We will be working towards a slightly revised vision for the service over this period, which is:

> To put things right for users of public services and to drive improvement in those services and in standards in public life using the learning from the complaints we consider.

Work was also undertaken during the course of the year to produce a Strategic Equality Plan. This was in accordance with the Equality Act 2010 and the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011. Also under the specific duties, I am required to produce an equality annual report. I have decided that it is most appropriate to do so within this Annual Report. Accordingly the activities of my office in relation to equality and diversity issues are reported at Section 8.

We have also continued with activities to raise awareness of the office and its work. This included holding a seminar for voluntary organisations in Wales. We also met with individual advice and advocacy bodies during the year. It was also a particular pleasure to welcome Mrs Rosemary Butler, the Assembly's Presiding Officer, to the office. My staff appreciated the time that she gave to them and the interest that she took in their individual roles.

I have previously reported on the work of a Welsh Government group that I was asked to chair, with the task of developing a common complaints procedure. I was very pleased that the advice offered to the First Minister on a Model Policy and Guidance for complaint handling for adoption by all public service providers in Wales was issued by the Welsh Government in July 2011. I know that some organisations, including the Welsh Government itself, have already put these new arrangements in place and I will be taking a keen interest over the next year to see what steps other bodies within my jurisdiction are taking to introduce the policy.

I have also welcomed the opportunity to be able to engage in discussions concerning the Social Services (Wales) Bill. Whilst at the time of writing this is still out to consultation, I am pleased that there is a proposal to bring private providers of care homes and domiciliary care agencies, as well as independent palliative care services into my jurisdiction. In particular, it has seemed unjust to me that a resident in a care home who has his or her care paid for by the state can complain to me about poor care, while a resident who pays for their own stay at the same care home cannot.

During the course of the year I also reviewed the governance arrangements of my office. I took the view that the office would better be able to demonstrate openness and transparency through the creation of an Advisory Panel. An open recruitment process began at the end of the year, with a view to members being appointed at the beginning of 2012/13.

In discussing governance, it would be remiss of me not to express here my appreciation for the work that Mr Laurie Pavelin has undertaken as Chair of the Audit Committee. His six years in the position came to an end on 31 March 2012. I have truly valued his wise counsel and support since the time I took up the office of Ombudsman and thank him for it.

Finally, thanks must also go to my staff. Every individual within the office has an important role to play in our success. The year has been one of innovation in terms of the introduction of a new service, enhanced communication methods and information technology developments. However, it has been equally notable for the continued hard work which has enabled us to stay on top of an ever-growing workload - in this regard, with the financial constraints on public services, I cannot see the trend reversing. I do not underestimate the challenges ahead of us.

Peter Tyndall
Ombudsman

2. The Role of the Public Services Ombudsman for Wales

The Public Service Ombudsman for Wales has two specific roles. The first is to consider complaints made by members of the public that they have suffered hardship or injustice through maladministration or service failure on the part of a body in my jurisdiction. The second role is to consider complaints that members of local authorities have broken the Code of Conduct.

Complaints about public bodies in Wales

When considering complaints about public bodies in Wales, I look to see whether people have been treated unfairly or inconsiderately, or have received a bad service through some fault on the part of the public body providing it. The bodies that come within my jurisdiction are generally those that provide services where responsibility for their provision has been devolved to Wales. More specifically, the organisations I can look into include:

- local government (both county and community councils);
- the National Health Service (including GPs and dentists);
- registered social landlords (housing associations);
- and the Welsh Government, together with its sponsored bodies.

When considering complaints I look to see that public bodies have treated people fairly, considerately and efficiently, and in accordance with the law and their own policies. If I uphold a complaint I will recommend appropriate redress. The main approach I will take when recommending redress is, where possible, to put the complainant (or the person who has suffered the injustice) back to the position they would have been in if the maladministration had not occurred. Furthermore, if from my investigation I see evidence of a systemic weakness, I will also make recommendations which aim to reduce the likelihood of others being similarly affected in future.

Investigations are undertaken in private and are confidential. When I publish a report, it is anonymised to protect (as far as possible without compromising the effectiveness of the report) the identity not only of the complainant but also of other individuals involved.

The Public Services Ombudsman (Wales) Act 2005 provides two ways for reporting formally on my investigations. Reports under section 16 of the Act are public interest reports and almost all are published. The body concerned is obliged to give publicity to such a report at its own expense. Where I do not consider the public interest requires a section 16 report (and provided the body concerned has agreed to implement any recommendation I may have made) I can issue my findings under section 21 of the Act. Depending on the nature and complexity of the investigation this will sometimes be in the format of a report, or it can take the form of a letter. There is no requirement on the body concerned to publicise section 21 reports or letters.

Occasionally, I need to direct that a report should not be made public due to its sensitive nature and the likelihood that those involved could be identified. For technical reasons, such a report is issued

under section 16 of the Act, even though it is not a public interest report, and I make a direction under section 17 of the Act. However, there have been no such reports issued this year.

The Public Services Ombudsman (Wales) Act 2005 also gives me the power to do anything which is calculated to facilitate the settlement of a complaint, as well as or instead of investigating it. In the right circumstances, a 'quick fix' without an investigation can be of advantage to both the complainant and the body concerned. Since taking up my role as Ombudsman, I have been keen to see greater use made of this power and that we seek to identify as many cases as possible that may lend themselves to this kind of resolution. I am pleased that it has been possible to increase even further the number of cases settled in this way this year (see page 16 for further information).

Complaints that members of local authorities have broken the Code of Conduct

My role in considering complaints alleging that members of local authorities have broken the Code of Conduct is slightly different to that in relation to complaints about public bodies. I investigate this type of complaint under the provisions of Part III of the Local Government Act 2000 and also relevant Orders made by the National Assembly for Wales under that Act.

Where I decide that a complaint should be investigated, there are four findings that I can arrive at:

(a) that there is no evidence that there has been a breach of the authority's code of conduct

(b) that no action needs to be taken in respect of the matters that were subject to investigation

(c) that the matter be referred to the authority's monitoring officer for consideration by the standards committee

(d) that the matter be referred to the President of the Adjudication Panel for Wales for adjudication by a tribunal (this generally happens in more serious cases).

In the circumstances of (c) or (d) above I am required to submit my investigation report to the standards committee or a tribunal of the Adjudication Panel for Wales and it is for them to consider the evidence I have found together with any defence put forward by the member concerned. Further, it is for them to determine whether a breach has occurred and if so, what penalty, if any, should be imposed.

3. Complaints of maladministration and service failure

Headline figures

- We received 1,866 enquiries, **up 66%** on 2010/11
- We received 1,605 new complaints, **up 13%** on 2010/11
- We achieved 176 quick fixes/voluntary settlements, **up 47%** on 2010/11
- We issued 178 investigation reports, **down 43%** on 2010/11
- We closed 1,547 cases, **down 5%** on 2010/11
- Number of cases on hand at 31 March 2012 was 455 cases, an increase of **54%** on 2010/11
- We had no investigations older than 12 months old open at 31 March 2012

Caseload – overall position

The number of complaints about public bodies that I receive continues to increase. As the figures in the table below indicate, the overall level of complaints has increased by 13% compared to the position for 2010/11.

	Total Number of Complaints
Cases carried over from 2009/10 (includes Code of Conduct complaints) New public body complaint cases 2010/11	 563 1,425
Total complaints 2010/11	**1,988**
Cases carried over from 2010/11 (includes Code of Conduct complaints) New public body complaint cases 2011/12	 295 1,605
Total complaints 2011/12	**1,900**
Cases to be carried forward to 2012/13 (includes Code of Conduct complaints)	 **455**

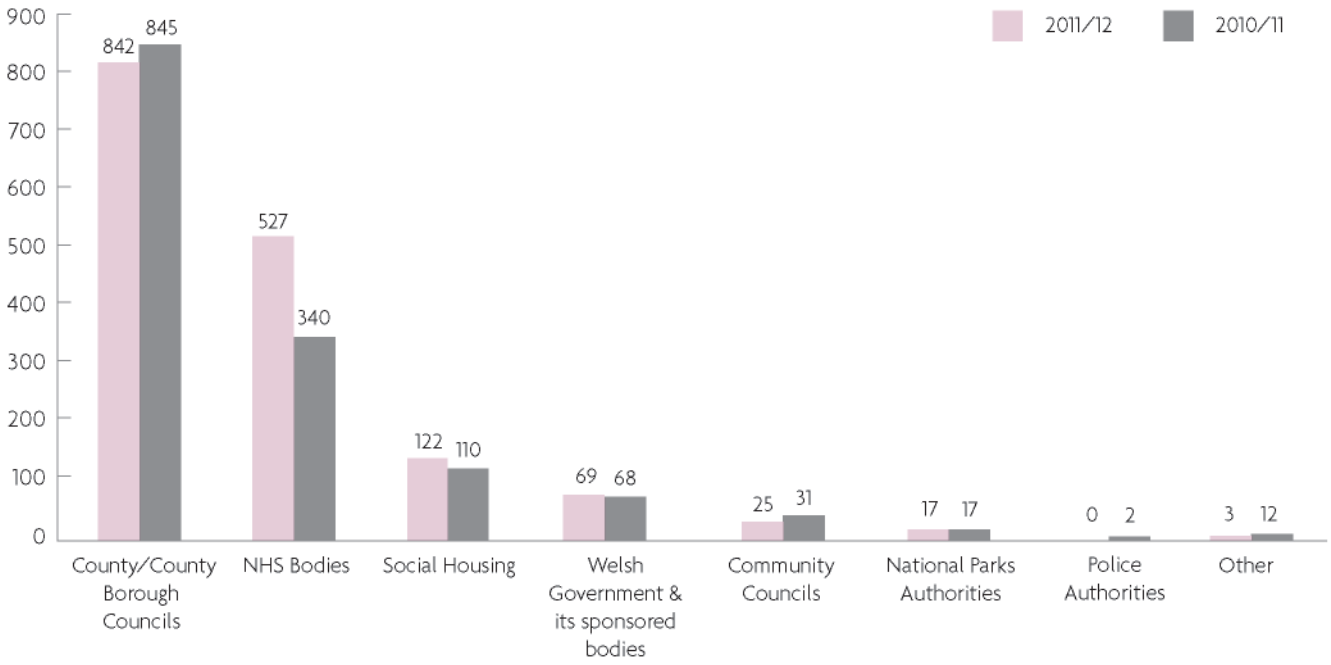
In addition, the office dealt with 1,866 enquiries during 2011/12, compared with 1,127 last year.

Whilst during 2010/11 we managed to cut the number of cases carried forward from one year to another to a caseload on hand of 295 from 563 in 2009/10, it is of some concern that the level of cases to be carried forward to 2012/13 will be 455. This to a great degree is accounted for by the fact that we have had to deal with an increase in cases received (including code of conduct cases – many of which were received near to the end of the year – see page 18)

Sectoral breakdown of complaints

The chart below shows the trends in complaints received per sector. Complaints about county councils continue to be the most numerous type of complaint received. This is to be expected given that they are direct providers of a wide range of services to the public. It is worth noting that the volume of county council complaints has remained fairly steady. The increase in health body complaints has, however, been exponential (527 complaints in 2011/12 compared to 340 in 2010/11).

Complaints by public body sector

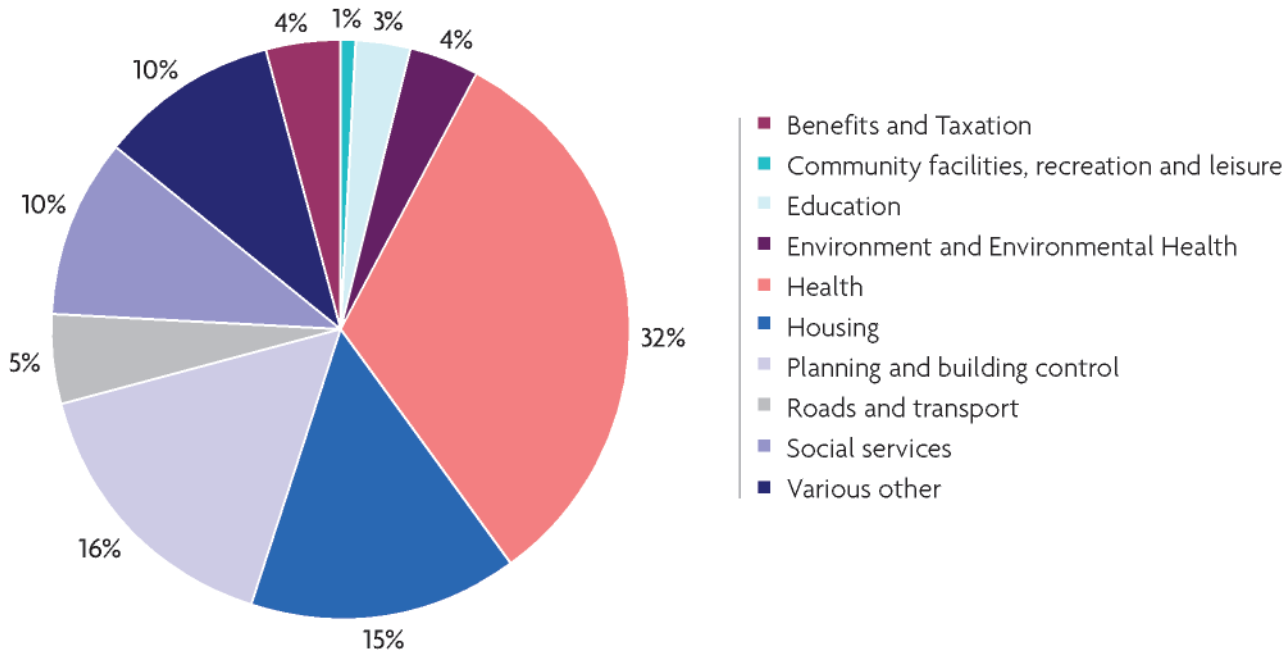


Complaints about public bodies by subject

The trend in relation to health complaints is confirmed when considering complaints by subject area. For the past four years, health complaints have been the most numerous types of complaint received. However, the increase in numbers of health complaints as a proportion of caseload continues to increase. As can be seen from the chart below, health now accounts for 32% of the caseload (this was 25% last year). Whilst it has to be borne in mind that the NHS Redress Measure came into force on 1 April 2011, I believe that this only partially accounts for the increase. I also believe that people are now more inclined to complain about poor service in the NHS than was previously the case and it is notable that almost half of health complaints are about clinical treatment in hospital.

Following the pattern of previous years, Planning and Housing are the next largest areas of complaint, accounting for 16% and 15% of the complaints received respectively during 2011/12.

Complaints by subject 2011/12



Outcomes of complaints considered

An overall summary of the outcomes of the cases closed during the past year, and a comparison with the position last year is given in the table below. Complaints included in the category 'Cases closed after initial consideration' include those received which:

- were outside of my jurisdiction
- were premature (that is, the complainant had not first complained to the public service provider, giving them an opportunity to put matters right)

- did not provide any evidence of maladministration or service failure
- did not provide any evidence of hardship or injustice suffered by the complainant
- showed that little further would be achieved by pursuing the matter (for example, a public body may have already acknowledged providing a poor service and apologised).

(A breakdown by listed authority of the outcome of complaints considered during 2011/12 is set out at Annex B.).

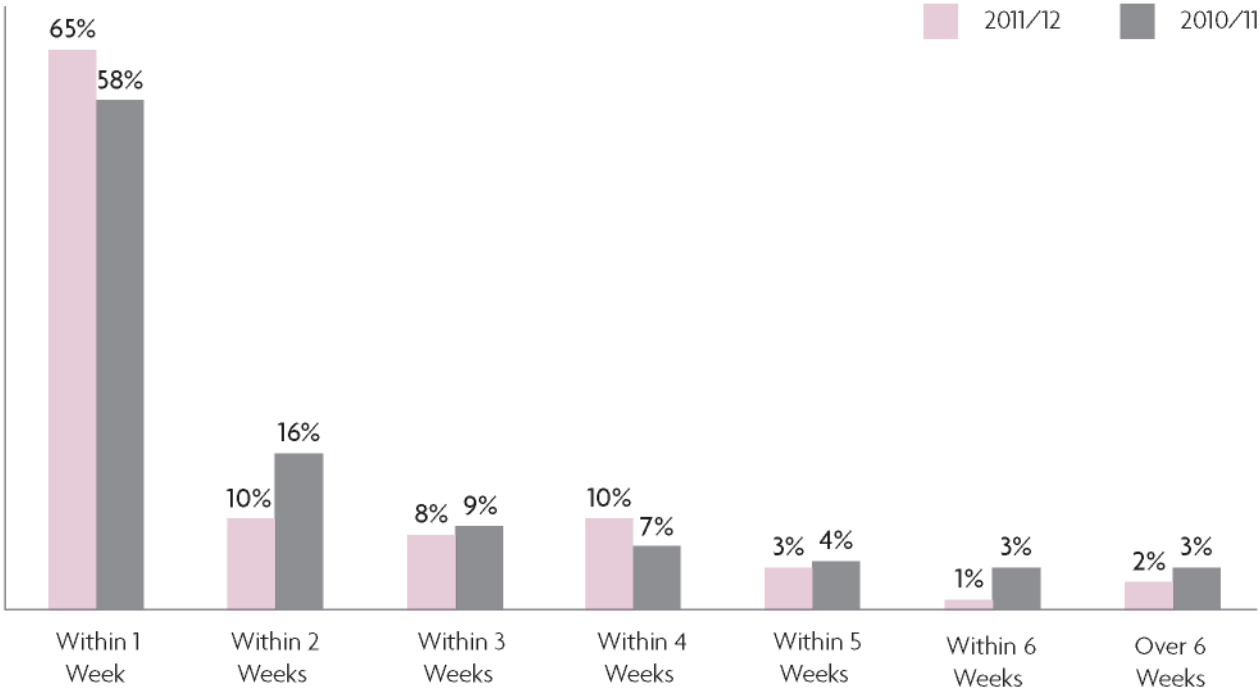
Complaint about a Public Body	2011/12	2010/11
Closed after initial consideration	1,158	1,113
Complaint withdrawn	16	48
Complaint settled voluntarily (includes ìquick fixî of 157 cases)	176	120
Investigation discontinued	19	38
Investigation: complaint not upheld	60	104
Investigation: complaint upheld in whole or in part	104	198
Investigation: complaint upheld in whole or in part – public interest report	14	13
Total Outcomes – Complaints	**1,547**	**1,634**

Decision times

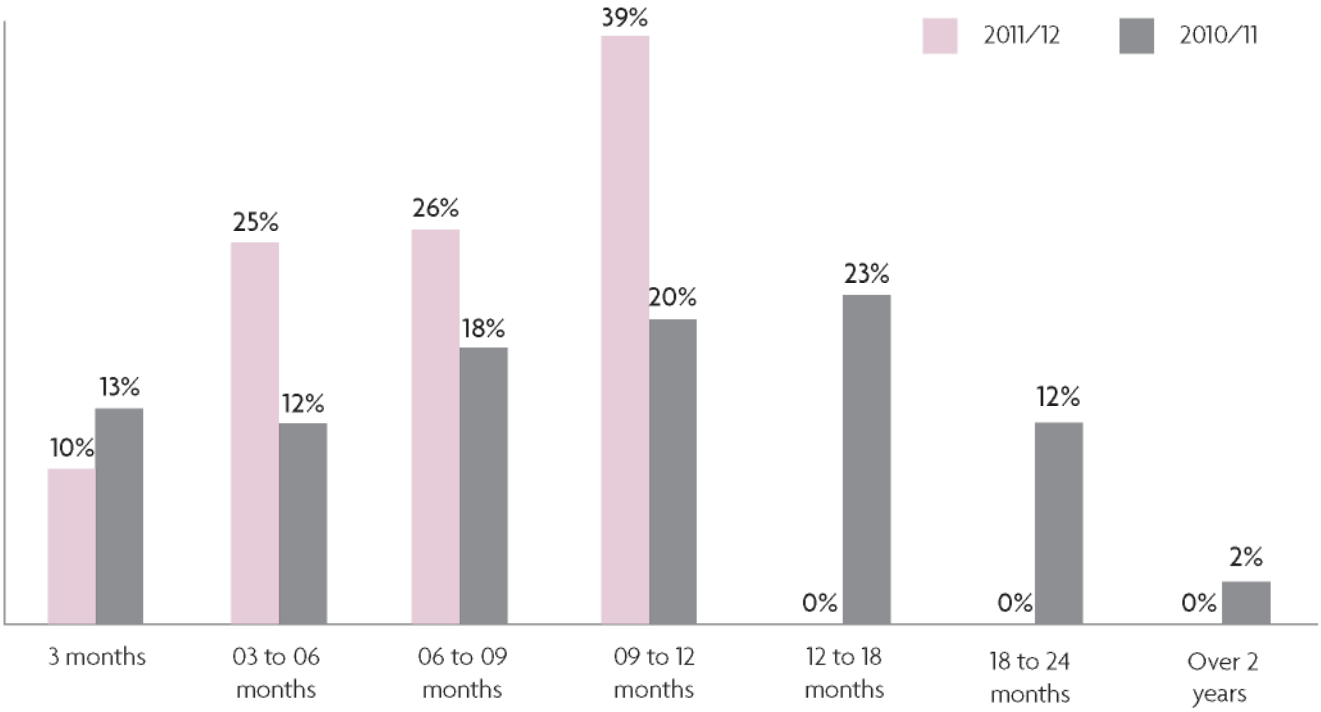
Below are two charts which report on the decision time targets we set ourselves. We aim to tell complainants within 4 weeks whether we will take up their complaint from the date that sufficient information about the complaint is received. Performance in relation to this target has continued to improve. We set ourselves the specific target of achieving the four week deadline 80% of the time. During 2011/12, this was achieved in respect of 94% of the complaints received.

The second target we set ourselves is to conclude cases within 12 months from the point that a decision is made to take up a complaint (that is, to commence investigation of a complaint). I am particularly pleased at the outcome illustrated below. However, I should point out that although in percentage terms the chart shows a 100% success rate, actually there was one case closed during the year which took longer than 12 months to investigate. This related to a complex children's social services complaint.

Decision times for informing complainants if complaint will be taken up



Decision times for concluding public body investigations



Complaints Advice Team

The Complaints Advice Team (CAT) provides our frontline service and responds to enquiries to the office. Enquiries are contacts made by potential complainants asking about the service provided, which do not, in the end, result in a formal complaint being made to me. At this point of first contact, we will act in various ways, such as:

- advise people how to make a complaint to me
- where appropriate, seek to resolve a problem without taking the matter to the stage of a formal complaint
- where people have not already complained to the relevant public body, we will advise them appropriately, sending their complaint directly to that body on their behalf if that is their wish.
- where the matter is outside my jurisdiction, direct the enquirer to the appropriate organisation able to help them.

However, beyond dealing with enquiries, the CAT is also charged with looking for effective, swift and innovative ways to resolve when we do receive formal complaints. They look to see if there are means to address complainants' concerns, without the need to progress matters to detailed investigation. We are increasingly making greater use of a 'quick fix' approach and even those people we cannot help appreciate receiving a decision promptly and by phone. I have been particularly pleased that against the target of achieving 100 quick fixes during the year, we actually resolved 157 complaints in this way.

Examples of 'quick fixes' achieved by the CAT are as follows:

Case 201101221 - Education/Transport

M R complained that he had been told by the Council to obtain the services of a driver to take his disabled daughter to school and that he would be reimbursed for the cost. He employed a driver, at a cost of £840. The Council refused to reimburse Mr R, as the driver did not drive a licensed taxi. Mr R said he had not been advised of such a requirement. The complaint had been ongoing for over a year. The documents from the Council did not show that Mr R had been told that it was a requirement to use a licensed taxi. My officer liaised with the Council officers who said that they believed that Mr R would have been told of the requirement, but they had no record of any such conversation. The Council agreed to reimburse Mr R the £840 and added a £60 time and trouble payment for the delay in its handling of the complaint.

Case 201102617 - Community Facilities

Mr F has had an allotment for many years and, in recent years, began to cultivate a piece of spare, overgrown land adjacent to his plot. He planted fruit trees there and erected a shed. He had moved home nine years previously, informing the Council of his change of address. However, following reorganisation around three years ago, the Council wrongly wrote to his old address when it gave him notice to remove the shed and trees from the plot. Mr F did not receive the notice and the Council proceeded to remove the shed. Mr F complained to the Council, who told him he was in breach of his allotment tenancy for not informing them of his change of address. My officer contacted the Council and explained that Mr F had informed it of his change of address and had received mail to the correct address for many years until the Council's reorganisation around three years ago. The Council accepted an error had occurred and provided Mr F with a new shed and paid him £60 redress to cover the cost of an item stored in the destroyed shed.

Case 201100842 - Council Tax

Mrs A complained that the Council had put the liability for Council Tax in her name, not her son's. She could not afford to pay the debt and the Council had passed the debt to Bailiffs. She had received notification from the Bailiffs that they would enter her home to remove goods to the value of the debt and Mrs A would not leave her home in case this happened. She and her son had tried to change the liability for the debt into her son's name, but had been told this could not be done. My officer spoke to the Council. It agreed to withdraw the Bailiffs from the case; put the liability in the name of Mrs A's son and advise him of the ways the debt and ongoing Council Tax bills could be paid.

Case 201002083 - Housing

Mrs H complained of a leaking pipe under her floor. A contractor had called but, after some considerable time, had not returned to carry out the repair. Despite numerous phone calls, nothing had been done. Mrs H was a vulnerable adult so my officer called the Housing Association to see if the repair could be expedited. By 1.00pm the same day, my officer received a call saying that a housing manager had called on Mrs H and a repair had been agreed. The Association promised to put in a new surface pipe, as opposed to ripping up the floor, within three working days.

Joint investigations

Under the PSOW Act, I am able to co-operate with other Ombudsmen and I draw attention in my Annual Reports to any such joint investigations. However, no complaints received by me or colleague Ombudsmen in other parts of the United Kingdom have necessitated such a joint investigation over the past year.

4. Code of Conduct Complaints

Headline figures

- We received 412 new complaints, **up 49%** on 2010/11
- We referred 19 investigation reports to either a standards committee or the Adjudication Panel for Wales, **down 58%** on 2010/11.
- We closed 345 cases, **down 1%** on 2010/11
- We had no investigations older than 12 months old open at 31 March 2012

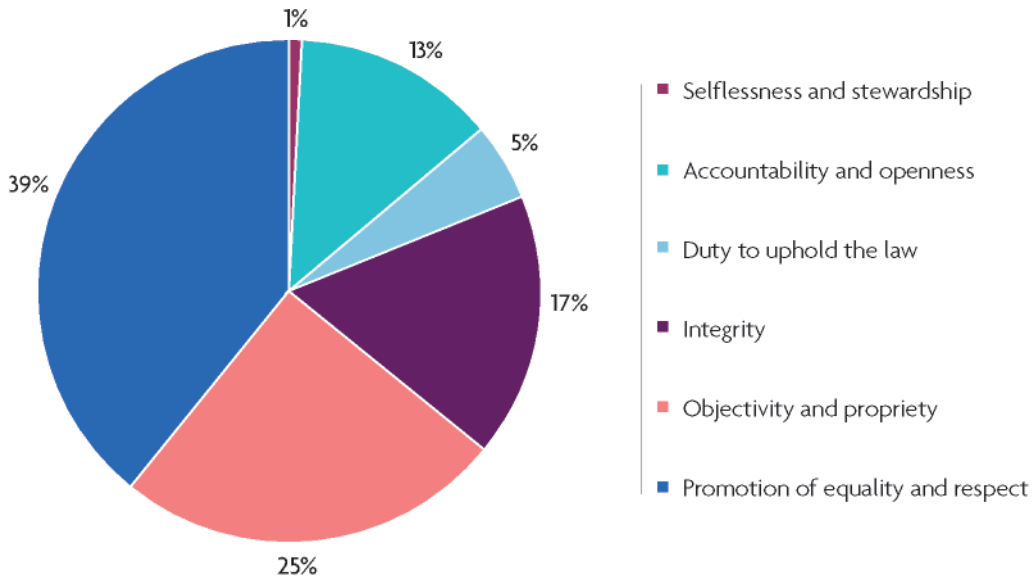
Complaints received

The table below gives a breakdown of the Code of Conduct complaints received by type of authority. Whilst last year I was pleased to report a decline in the number of complaints received, I have been particularly concerned to see the increase in the number of complaints received this year, which has increased by 49%. I address this increase later in this section.

	2011/12	2010/11
Community Council	206	141
County/County Borough Council	177	135
National Park	28	1
Police Authority	1	-
Total	**412**	**277**

Nature of Code of Conduct complaints 2011/12

As the chart below shows, the majority of complaints received during 2011/12 related to matters of 'equality and respect' (39% compared to 57% in 2010/11). However, there was a noticeable increase in the number of complaints relating to 'objectivity and propriety' over the past year, accounting for 25% of the Code of Conduct complaints received compared to 10% in 2010/11.



Summary of Code of Conduct complaint outcomes

Of the Code of Conduct cases considered in 2011/12, the majority were closed under the category shown below as 'Closed after initial consideration'. This includes decisions such as:

- there was no 'prima facie' evidence of a breach of the Code
- the alleged breach was insufficiently serious to warrant an investigation (and unlikely to attract a sanction)
- the incident complained about happened before the member was elected (before they were bound by the Code).

The number of cases which I concluded should be referred to either an authority's standards committee or to the Adjudication Panel for Wales was 19 compared to 45 in 2010/11.

	2011/12	2010/11
Closed after initial consideration	270	194
Complaint withdrawn	12	16
Investigation discontinued	9	43
Investigation completed: No evidence of breach	7	13
Investigation completed: No action necessary	28	38
Investigation completed: Refer to Standards Committee	15	21
Investigation completed: Refer to Adjudication Panel	4	24
Total Outcomes – Code of Conduct complaints	**345**	**349**

(A detailed breakdown of the outcome of Code of Conduct complaints investigated, by local authority, during 2011/12 is set out at Annex C.).

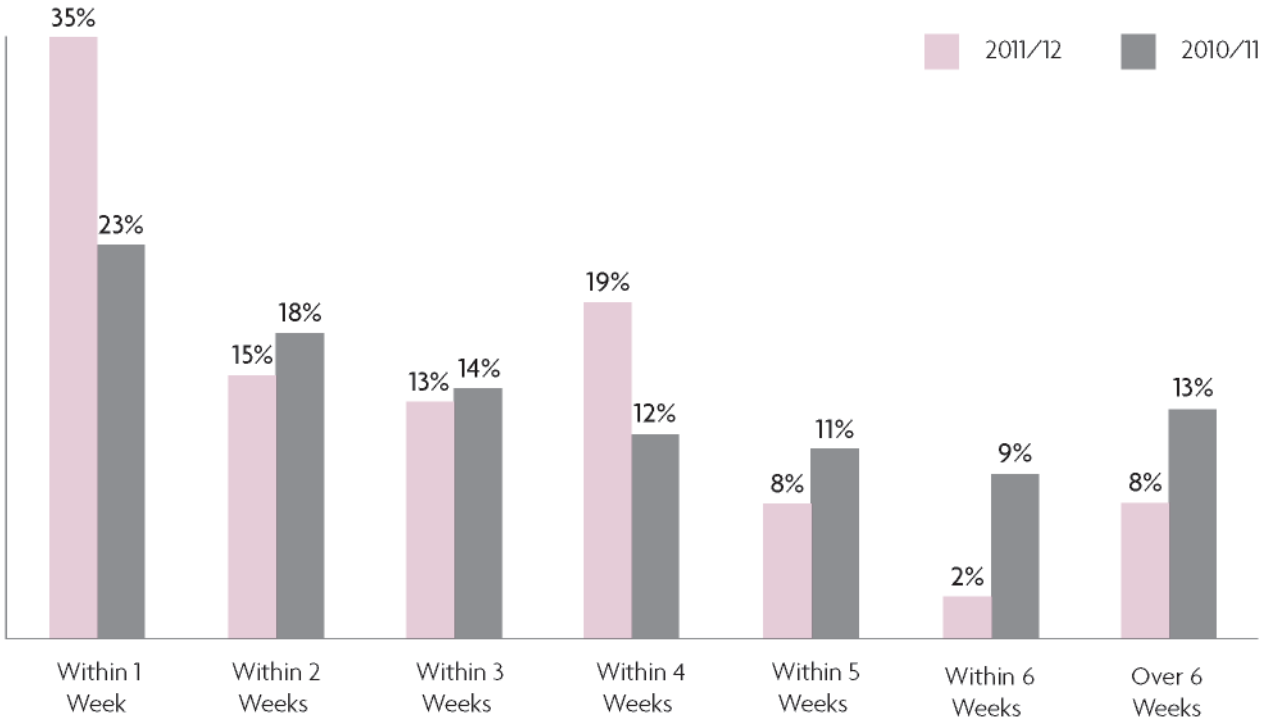
Decision times

Below are the decision times for Code of Conduct complaints. The time targets set for Code of Conduct complaints are similar to those for complaints about public bodies, i.e.

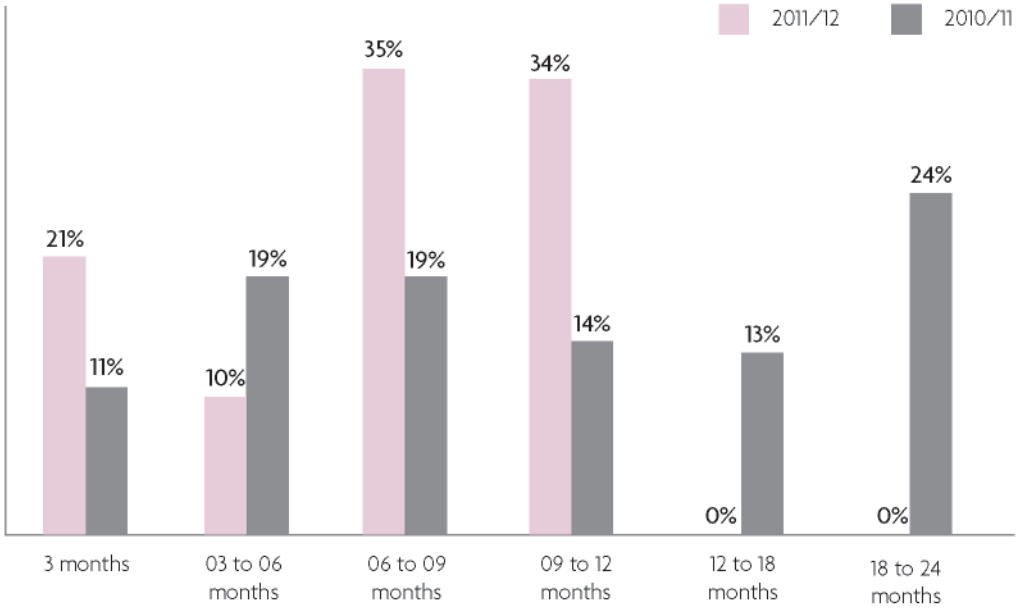
- to tell complainants within 4 weeks whether we will take up their complaint from the date that sufficient information about the complaint is received
- to conclude cases within 12 months from the point that a decision is made to take up a complaint (that is, to commence investigation of a complaint).

I am pleased that in terms of the overall caseload of complaints we received (both public body and Code of Conduct), we have surpassed the overall general target of achieving the four week deadline 80% of the time. However, we have to deal with Code of Conduct complaints in their initial stages in a different way compared to those in respect of public bodies. In respect of Code of Conduct cases we achieved the target 82% of the time. But again, this is an improvement on last year's position, when the target was achieved 67% of the time. The detailed position is set out in the chart below.

Decision times for informing complainants we will take up their complaint



Decision times for concluding Code of Conduct investigations



I have commented in previous Annual Reports about my concern about the time it has been taking to deal with Code of Conduct investigations. I have also previously explained that this is partly due to the consequences of members increasingly engaging legal representation. In 2009/10 we changed our process with a view to improving performance. I am pleased to be able to report therefore the changes introduced are now bearing fruit. As the chart above indicates, no code of conduct investigations took longer than 12 months to complete.

Commentary on the increase in the number of Code of Conduct complaints

It is not surprising that the increase in the number of Code of Conduct complaints received has occurred during the year in the run up to county council elections. I am extremely disappointed that it appears that the Code is being used in this way.

I am also concerned about certain practices emerging amongst town and community councils. It became necessary during the year to correspond with the Clerk of Prestatyn Town Council in relation to our mutual concern about the number of complaints I receive in respect of members of Prestatyn Town Council. During 2011/12, I received 65 complaints out of a total of 206, representing 32% of the complaints about town and community councils. This level of complaints is entirely disproportionate. Such a level of complaints, in my view, reflects a very hostile set of interactions between councillors and must inevitably lower the esteem in which the Council is held by its electors. I have urged the Council to reflect on the culture which is giving rise to these complaints and how behaviour might be changed to reverse this trend. I am also aware that some of these complaints are being made by a small number of members of the public and one person in particular. I will actively consider what further steps are available to me to tackle the problem. In particular, if there is no reduction in the number of complaints by members against other members, the Code has explicit provisions regarding vexatious

complaints and I will not hesitate to invoke them. I have urged the members of Prestatyn to develop the Council so that its reputation steadily improves.

Code of Conduct for local authority members – changes to practice

In recognition of concern about certain aspects of the Code and the use of complaints for political purposes, I have been in discussion with the Welsh Local Government Association (WLGA), the Association of Council Secretaries and Solicitors (ACSeS) and the Welsh Government on a range of measures designed to reform the current Code of Conduct system, which can be achieved without the need for legislation. The aim is that these measures will enable a local resolution process to be introduced across Wales which should greatly reduce the number of complaints brought by councillors against other councillors which need to be considered by my office.

The first element of this new approach was introduced at the beginning of 2012, and applies to members of county/county borough councils and community/town councils. When I am minded not to investigate a complaint or having commenced an investigation I am minded to close my investigation, I will write to the Monitoring Officer. This will arise when I judge that even if the Standards Committee did find that there had been a breach of the Code, it would be unlikely to administer a sanction. It will then be for the Monitoring Officer to consider the matter. If they take a different view on the likelihood of the Standards Committee applying a sanction if they decide that there has been a breach of the Code then I will transfer the investigation to them for local consideration.

In April 2010, in response to requests from local authority monitoring officers and others, I issued guidance for local authority members on the Model Code of Conduct issued in 2008. This was developed following an initial consultation inviting local authorities to identify which aspects of the Code they would value guidance upon, and a subsequent consultation with the Association of Council Secretaries and Solicitors, One Voice Wales, the Welsh Assembly Government and the Adjudication Panel for Wales on the draft. That guidance however was revised at the end of 2011/12 to reflect the above changes, and has been placed on my website. I previously made it clear that the guidance should be a 'living' document and it is intended to make further revisions and provide additional guidance on the Code in the early part of 2012/13.

Standards Committee and Adjudication Panel for Wales's Hearings – Indemnity Cap

I have also been in discussions with the WLGA regarding the scale of indemnity offered by Welsh local authorities to their members when defending themselves against alleged breaches of their Code of Conduct, especially when facing tribunals convened by the Adjudication Panel for Wales.

I have proposed that a cap of £10,000 should be put in place. As a councillor could face disqualification, I believe that in seeking a parallel, it is helpful to consider employment tribunals, where claimants may have lost their employment. In these instances, awards of costs are limited to £10,000, offering a useful comparator. I have said that I would then match the £10,000 cap in respect of my own costs. At the time of writing I am awaiting a formal response to my proposals on this matter.

5. Improving Public Service Delivery

My main role as an Ombudsman is to consider individual complaints. However, I place great importance on ensuring that we identify the wider learning that can be derived from the outcomes of complaints. Sharing this learning gives great potential for improved public service delivery in Wales.

Public interest reports

My ability to issue public interest reports, under section 16 of the PSOW Act is a key instrument enabling me to share learning from the investigations I undertake. It means that I am able to achieve a benefit beyond providing redress for the individual and making recommendations to ensure that the systemic problems identified are addressed by the body concerned. It enables wider learning among similar public bodies, and prompt and encourage them to ensure that no similar systemic problems exist in their own organisation. These public interest reports also alert members of the public to the issues identified and can prompt them too to make a complaint if they have suffered from similar failings.

I issued 14 public interest reports during 2011/12. Summaries of these are at Annex A and their full text is available on my website at www.ombudsman-wales.org.uk

Section 21 reports and 'The Ombudsman's Casebook'

The vast majority of my investigation reports are not formally publicised because the matters raised in the individual cases are not considered to be of public interest in themselves. Nonetheless, when upheld, these investigations often identify failings within the body concerned, which it agrees to rectify as part of the recommendations that I make. This can include, for example, improved training, changes to management practices or improved procedures.

However, during 2010/11 I decided to introduce 'The Ombudsman's Casebook', a case digest. This was developed to reflect the fact that although individual cases of this type may not be of 'public interest', when considered amongst a number of similar complaints and outcomes, there may well be lessons that public bodies can learn from these complaints too. We issued four case digests during 2011/12. The Casebook has a wide circulation which includes bodies in jurisdiction and Assembly Members, as well as individuals who have 'signed up' to receive a copy. I have been very pleased with the feedback that I have been receiving from all quarters concerning this publication. I intend to expand the content of the Casebook during 2012/13 so that it also includes learning from those cases that we resolve informally (i.e. the quick fixes).

Topics addressed in the four digests published during 2011/12 are set out below. In view of the increasing number of health complaints that I receive, it is not surprising that health was also the key focus of issues raised and were as follows:

- lack of care for people at the end of their lives
- ensuring patients receive proper follow-up care
- concerns about Nursing and Midwifery Care

- inadequate Weekend/Out of hours medical cover
- removal of patients from GP lists
- inadequate assessments.

Subjects also addressed in the Casebook over the past year were:

- poor complaint management
- conflict of interest and impartiality in dealing with complaints
- failures to make provision for children's special educational needs
- responsibility for housing repairs.

Annual letters

For the second year I issued Annual Letters to county/county borough councils and health boards. This time these were published on my website. I have continued to limit issuing such letters to these organisations, as I do not receive the necessary volume of complaints in respect of the other types of bodies to enable meaningful comparisons on an all Wales basis and to identify any trends. I have been heartened that many bodies have accepted them as a learning tool, enabling them to have greater understanding of their own organisation's 'performance' beyond that possible to provide in my Annual Report.

Complaints Wales signposting service

I reported last year on the background to the provision of a new service by my office, the Complaints Wales signposting service. I am pleased to be able to report this year that that service has now been launched. It is delivered by my Complaints Advice Team.

Complaints Wales is a telephone and web service. Its aim is not only to advise people on which public service provider they should complain to, but also to capture the crux of their complaint and (with the complainant's consent) send the details on to the relevant public body on their behalf. The service signposts complaints not only in respect of public services devolved to Wales but also in relation to non devolved public services – for example, benefits and pensions. It also assists in relation to organisations such as the utility companies, which many people still consider to be 'public services', despite deregulation having taken place many years ago. Furthermore, if people have already complained directly to the service provider, then the service will signpost them to the relevant ombudsman or other complaint handling body.

The development of the service has meant a considerable amount of data gathering. The web service in particular has been a complex technical development, especially in relation to the integration of the website with my complaints handling database (see further details at page 29). I believe that in terms of the ombudsman community we are a world leader in this initiative.

Model complaints policy and guidance for public service providers

I reported last year on the work of an Assembly Government working group that I was asked to Chair where proposals had been put forward to the First Minister in respect of a common complaints handling process for public service providers in Wales. I am pleased that the advice submitted received a positive response and that the Welsh Government issued the model policy and guidance in July 2011, urging all public service providers to adopt the model. Some organisations have now implemented the policy and guidance, and this includes the Welsh Government itself, and I am aware that a number of organisations are making preparations to do so. Furthermore, it is my intention to recommend that the body concerned adopts the model policy and guidance where, during an investigation, I find that there has been poor complaints handling.

The model policy and guidance was developed at the same time as the new health complaints procedure under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. These complaint procedures are consistent with and complement each other. I very much hope that a similar position will result from the current review of the social services complaints procedure.

6. Governance and Accountability

The Ombudsman

The Public Services Ombudsman (Wales) Act establishes the office of the Ombudsman as a 'corporation sole'. I am accountable to the National Assembly for Wales, both through the mechanism of this annual report, and as Accounting Officer for the public funds with which the National Assembly entrusts me to undertake my functions.

Governance arrangements

Advisory Panel

During 2011/12, I reviewed the governance arrangements of my office, whilst bearing in mind the constitutional position of a corporation sole and the fact that responsibility and accountability for the activities carried out by the office must remain with the Ombudsman. My predecessor introduced an advisory Audit Committee (see below), which has proved a valuable source of advice. However, to enhance openness and transparency, I considered that the office would benefit from the creation of an Advisory Panel. The role of the Panel in underpinning excellent governance will be to provide support and challenge to the Ombudsman.

Recruitment for the Advisory Panel began in March 2012, with a view to appointing Panel Members by the end of May.

Audit and Risk Committee

The use that I make of the resources available to me is subject to the scrutiny of the Wales Audit Office, which is responsible for auditing my accounts. This work was outsourced to Grant Thornton UK LLP by the Wales Audit Office in 2008/09. The Auditor General, however, remains ultimately responsible for the external audit function.

Although a 'corporation sole', I have an Audit Committee which is charged with advising me in discharging my duties as Accounting Officer. The Chair of the Committee has been Mr Laurie Pavelin, CBE, FCA. Mr Pavelin's term as Chair came to an end on 31 March 2012 and recruitment for a successor is taking place in tandem with the recruitment for the Advisory Panel members. In addition, Professor Margaret Griffiths serves as an independent Member, who brings her considerable legal expertise, particularly in the Welsh context. I am also a member of the Committee in my capacity as the Accounting Officer.

The Audit Committee considers matters including budget estimates, annual accounts, external and internal audit reports, and risk management issues. It also considered matters including the Strategic and Operational Plans during 2011/12, although this responsibility will transfer to the Advisory Panel from 2012/13. The Audit Committee met four times during 2011/12 and I am pleased that no substantive matters of concern were raised during the year.

Following a tender/interview process, Deloitte began on their work as my internal auditors from 1 April 2011. Their programme of work is guided and overseen by the Audit Committee and the first year has seen the development of a good and constructive relationship.

Management Team

Whilst I am solely accountable for the decisions and operation of my office, the Management Team is a formal group that provides me with advice and support.

It takes specific responsibility for advising me on the development of the three year Strategic Plan and the annual Operational Plan; annual budgetary requirements; ensuring the best use of the public money received; and an appropriate performance monitoring framework.

It is also responsible for the delivery and monitoring of strategic aims; monthly performance monitoring against objectives; ensuring that risks are actively identified and addressed; agreeing corporate policies (e.g. complaint handling procedures, human resources policies) and monitoring their effectiveness; and developing the office's outreach strategy and monitoring its implementation.

Three Year Strategic Plan and Business Plan

At the end of March 2012, I published the Strategic Plan for the next three years. This was developed with the involvement of all staff in my office. We have introduced a revised Vision as well as establishing new key strategic aims for the three years ahead of us. Whilst much of the Plan takes forward the innovations introduced over the past couple of years, there is also focus on preparing for the new areas of jurisdiction which are likely to be introduced to my office as a result of the Social Services (Wales) Bill. I also published the annual Business Plan for 2012/13 at the end of March, which flows from the Strategic Plan and sets specific targets and performance indicators for the year ahead.

Strategic Equality Plan

Under the Equality Act 2010 and the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 laid down by the National Assembly for Wales, I published my Strategic Equality Plan at the end of March 2012 (compliant with the requirement to issue the Plan before 2 April 2012). Under the specific duties, I am required to report annually on relevant equality issues. I do so under Section 8 of this Annual Report.

7. Other Activities

Complainant satisfaction research

Research via complainant satisfaction surveys has been an important means of understanding complainants' views of the service we provide.

Last year we began a new approach, conducting quantitative surveys of those complainants who contact our Complaints Advice Team, with Opinion Research Service (ORS) providing us with a more focussed in-depth qualitative survey of those people whose complaints were taken to investigation. They do so on a sample basis with interviews usually being undertaken by phone, but face to face if this is more appropriate in the circumstances of the complainant. The aim is to achieve an even better understanding from the complainant's perspective of what we do well and what we can perhaps improve upon.

In relation to the first contact survey work, the outcome of responses received during 2011/12, where service users were asked whether they agreed or disagreed with the statements below is as follows:

	% of respondents answering either 'strongly agree' or 'agree'
It was easy to find out how to contact the Ombudsman's office	83%
The service I have received so far has been helpful and sensitive	68%
The person that dealt with the query knew enough to be able to answer my questions	67%
I was given a clear explanation of what would happen next to my concern	74%
The service provided what I expected of it	63%

With regard to the qualitative work that ORS has undertaken for us, as in previous research work we have commissioned, complainants' views are heavily influenced by the outcome of their case. Typically, those whose cases were fully upheld or voluntarily settled to their satisfaction were far happier with the service they received than those whose cases were not upheld or discontinued without settlement (and even some whose cases were upheld, but not fully).

Comments of a positive nature included the politeness of staff and their empathy, efficiency, communication and interpersonal skills, professionalism and neutrality. The majority of those interviewed were also impressed with the thoroughness of their investigation and the conscientiousness of individual investigators.

Those who were not content had a perception that the Ombudsman undertook a superficial investigation, did not wish to 'rock the boat', did not answer questions sufficiently or provide explanations for what had happened, or was biased in favour of the public body. Some felt that there was: an inappropriate offer of 'compensation'; an insufficient explanation of the decision taken; a sense that complainants are less important than the public bodies under scrutiny; and that a decision in favour of the public body sanctions 'poor practice'. There is some belief that the Ombudsman has insufficient powers and does not go far enough in ensuring that poor practice is dealt with effectively so that public authorities change their practices. (It should be noted that all of the Ombudsman's recommendations have been implemented.)

We have been making progress in relation to managing people's expectations of what the Ombudsman can and cannot do, but it appears that we still have more work to do in this area, including emphasising that the Ombudsman cannot act as an advocate.

Information technology

Case handling administration system

April 2011 saw the introduction of a major upgrade to the case handling administration system. This development work took place as it was evident that our then existing system would no longer be fit for purpose. As is often the case with new technological systems, this was not without its problems. However, I am pleased to say that these have now been ironed out and that the system is now operating in the way expected.

Websites

We also developed new websites, one for the core Public Services Ombudsman for Wales service, the other for the new Complaints Wales signposting service. The websites and complaint handling system have now been integrated, and a key benefit is that the data service users enter onto the webforms are automatically populated into case records on the complaints handling administration system.

External communication

Increasingly the internet is the means by which people learn about the work of the ombudsman. Indeed of those who returned our monitoring forms during 2011/12, just over a quarter indicated that this was the means by which they found out about the office. This is an important 'shop window' for the office therefore. I have been keen that my website should appear more welcoming and easier to navigate. Therefore, in addition to introducing the technology to enable integration between the webforms with the complaints handling administration system, we also sought to develop a more user friendly website, introducing for the first time also a new Complaints Wales website.

Our new websites

We have also been assessing what use we could make of developments in social media, and as a result undertook an additional piece of work at the end of March 2012, which will enable us to introduce 'Twitter', as a feed on the PSOW website, during April 2012.

Complaints Wales

The Complaints Wales service was 'soft launched' during 2011/12 in order to ensure that there were no teething problems, particularly with the new technology, before widely promoting the new service. I was satisfied by the beginning of 2012 that the service was sufficiently established to begin the work of widely publicising the service. A publicity campaign began mid-March 2012, therefore, with a view to sending a leaflet to every household in Wales (i.e. over 1,400,000 homes).

The leaflet has also been produced in eight minority ethnic languages (placed on the website) and is available in Braille.

Outreach

A substantial proportion of our communication activities and resources have been channelled towards the Complaints Wales service over the past year, as referenced above. We also held a seminar for voluntary organisations in Wales, where we explained the new Complaints Wales service and how this could help them and their clients; we also however took the opportunity to discuss the core work of the Ombudsman's office.

We continued to take opportunities to speak at conferences and seminars, where possible. For example, the conferences of Community Health Councils, End of Life Alliance and Dignity in Practice. We also met with organisations such as Age Cymru, Learning Disability Wales and Hospices Cymru.

The outreach work of the office was enhanced by significant media attention to my investigation reports. I have been particularly pleased with the high level of television and radio coverage (both English and Welsh language) received during 2011/12, particularly so during the second half of the year. This helps to raise awareness not only of the issues of concern identified but also of the service that I provide in general. New media monitoring arrangements were also introduced in May 2011, which provides improved knowledge of articles referring to the work of the office both amongst the UK and Welsh press. From May 2011 to March 2012, there were 208 articles mentioning the Public Services Ombudsman for Wales.

Human resources

As Ombudsman, I am keenly aware of how fortunate I am in having a committed and expert workforce. I equally recognise the importance of ensuring that I provide the opportunity to enable continual development. Revised staff appraisal and training arrangements were introduced during 2011/12 and these are closely linked to our business objectives.

The service level agreement in place with the Wales Audit Office to provide me with advice on human resources matters continues. I have highly appreciated the assistance that I have received during the past year.

I will continue to monitor the level of increase in complaints received during the course of the year as well as undertake an assessment on the impact of the likely extension to my jurisdiction as a result of the Social Services (Wales) Bill. There is no question that delivering the service expected by those people who complain to my office will pose a substantial challenge, and I will need to carefully monitor the rate of increase in complaints to ensure that the reduced capacity of my office can continue to deliver the high quality service that service users expect.

The organisational structure of my office showing the position as at 31 March 2012 is shown at the end of this section.

Best practice in the world of the Ombudsman

I consider the work of the British and Irish Ombudsman Association (BIOA) to be important. Ombudsman schemes need to be objective and maintain an appropriate distance from the bodies in jurisdiction. Consequently, it is essential that we learn from the best practice of other similar ombudsman schemes. BIOA offers the opportunity to share best practice, learn from one another and discuss common issues of concern. Members of my staff represent me on a number of the BIOA Interest Groups.

The BIOA Biennial Conference was held during 2011. Having had the honour of being appointed as Chair of BIOA during 2010, I was naturally fully involved in arrangements and in presiding over the two days. I would like take the opportunity here to thank my support staff for providing some additional support to BIOA by helping out with administrative arrangements at the conference. It also reflected well on the Ombudsman's office in Wales that two members of my staff were speakers at separate sessions during the conference. I was also pleased that my office was able to host a meeting of the BIOA Executive Committee in September 2011.

BIOA has developed with Queen Margaret University in Edinburgh an accredited training course for staff of ombudsman/complaint handling schemes. Having received requests from staff of bodies within my jurisdiction for training for investigation of complaints, I have taken the opportunity to enter into a joint arrangement with the University so that they can provide similar training for complaints handling staff within public service organisations in Wales. A pilot course will take place in May 2012. The success of this will be assessed and a view will then be taken as to whether this should be rolled out further.

Increasingly, the International Ombudsman Institute is also becoming an important network for my office in terms of shared learning. I was, therefore, particularly pleased to be able to welcome Senyor Rafael Ribó, the Catalan Ombudsman and Chairperson of the European Region of the International Ombudsman Institute to my office at the beginning of March 2012 and was proud to be able to provide him with a taste of Wales's St David's Day celebrations, including those at the Senedd.

I greatly value too the continued opportunity to participate in the UK and Ireland Public Sector Ombudsmen meetings, as I do the regular meetings that I have with the Children's and Older People's Commissioners for Wales. I was also particularly pleased to welcome the new Welsh Language Commissioner to my office, where my staff and I explained the way we operate and shared some of our experience.

Complaints about the PSOW service

The 'Complaints about us' procedure can be used if someone is unhappy about our service. For example, a complainant may wish to complain about undue delay in responding to correspondence; or feel that a member of staff has been rude or unhelpful; or that we have not done what we said we would. There is a separate procedure for complainants wishing to appeal against a decision on their complaint. Further details about both these procedures are available on my website: www.ombudsman-wales.org.uk.

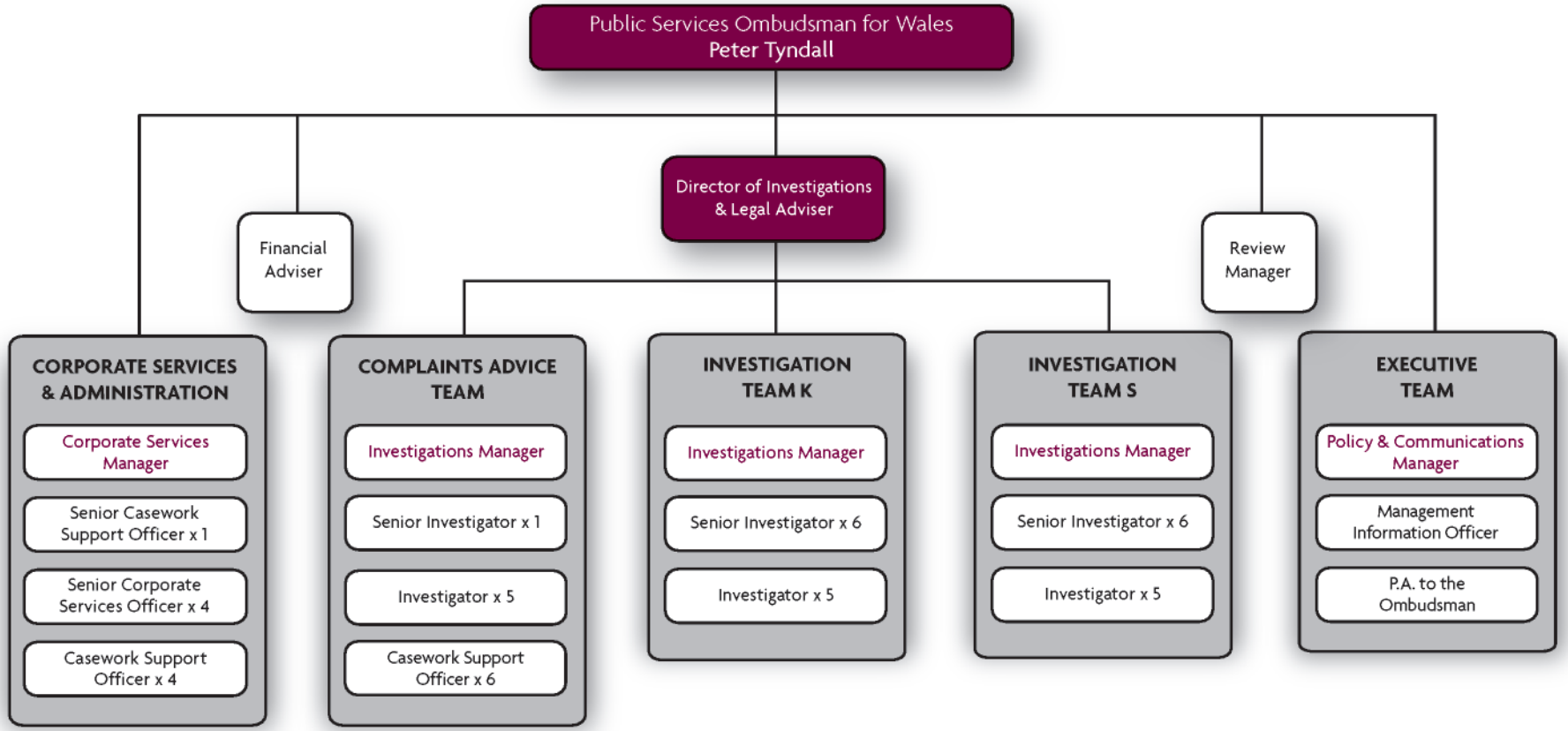
The table below reports on the number of complaints received during 2011/12 and their outcomes, together with a comparison of the position in 2010/11.

Details of the 'complaints about us' received	2011/12	2010/11
Not upheld	24	21
Upheld in whole or in part	5	3
Referred to Investigation Manager/Investigator (investigation decision related)	6	4
Complaint withdrawn	1	0
Still open at 31 March	2	5
Total received	**38**	**33**

Details of the five cases upheld in whole or in part during 2011/12 are as follows:

Subject of complaint about us	Action taken
Complaint concerned lack of regular updates and undue delay in investigation.	Letter of apology sent.
Complaint concerned a request for information contained within an investigation comeback letter which was not picked up by the investigator.	Letter of apology sent and staff reminded of importance of forwarding on both 'Complaints About Us' and information requests to relevant department.
Complaint that the complainant was not informed in a timely manner of a new investigator assigned to their case.	Letter of apology sent.
Complainant dissatisfied by being addressed in first name terms in correspondence.	Letter of apology sent.
Complaint concerned undue delay in updates about their complaint.	Letter of apology sent.

Organisational Chart (position as at 31 March 2012)



8. Equality Issues

A commitment to treating people fairly is central to the role of an ombudsman. As Public Services Ombudsman for Wales, I am committed to providing equal opportunities for the staff in my employment and in the service we together provide to complainants. No job applicant, staff member or person receiving a service from the PSOW will be discriminated against, harassed or victimised due to personal characteristics such as age, disability, ethnicity, sex, gender reassignment, pregnancy or maternity, sexual orientation, religion or belief, whether they are married or in a civil partnership, or on the basis of any other irrelevant consideration. I expect my staff to share my total opposition to unlawful and unfair discrimination and my commitment to conducting business in a way that is fair to all members of society

Under the Equality Act 2010 and the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 laid down by the National Assembly for Wales, I have a duty to publish a Strategic Equality Plan and equality objectives. The first such Plan, which contains my equality objectives, was published at the end of March 2012 and complied with the statutory requirement to publish before 2 April 2012. (The Plan is available on my website: see www.ombudsman-wales.org.uk). Also under the specific duties, I am required to produce an annual report in respect of equality matters. Clearly, the degree to which I can report on progress against the Strategic Equality Plan is limited bearing in mind that it was not published until March 2012. However, I will report below on work undertaken in relation to equality considerations since the inception of the office of the PSOW on 1 April 2006.

Accessibility

As part of our process, we do our very best to identify as early as possible any individual requirements that may need to be met so that a service user can fully access our services and, in particular, we ask people to tell us their preferred method of communication with us. We always try to make reasonable adjustments where these will help people make and present their complaint to us. Examples are: providing correspondence in Easy Read; using Language Line for interpretation, where a complainant is not comfortable with making their complaint in English or Welsh; obtaining expertise to assist us to understand the particular requirements of complainants with certain conditions, such as Asperger's syndrome; and visiting complainants at their home.

We produce key documents in alternative formats, such as CD/tape and Braille, translate these into the eight key ethnic minority languages used in Wales; and we have upgraded the accessibility of our website from A to AA compliant and introduced BrowseAloud which allows the website to 'talk' to the user.

Equality Data Gathering/Monitoring – Service Users

We have always undertaken equality monitoring in respect of service users, which has informed our annual outreach strategy. Results of equality monitoring undertaken to date in respect of service users has been published in the Strategic Equality Plan. Our own equality monitoring has been supplemented by equality monitoring questions asked during our customer satisfaction surveys undertaken on our behalf by Opinion Research Services. We have used the evidence from these satisfaction surveys to improve our service. For example, by removing certain barriers such as not always requiring complaints to be made in writing and allowing them to be made by phone, email or through our website. We intend to enhance the equality monitoring that we undertake in-house, including developing our complaints handling system to enable analysis between groups and outcomes of complaints. (Note: access to this data will be strictly limited to two members of staff not involved in considering/ investigating complaints.) We will use this intelligence to identify any areas that could improve our customer service, including equality considerations.

Training

My staff have over the years received equality and diversity training. We have done this for two reasons. Firstly, so that in the service we provide we can be responsive to the changing needs and requirements of people with whom we communicate and interact. Secondly, so that we have the knowledge to be able to identify during our investigations any failings by public service providers in respect of equality duties. Examples in this latter regard can be found amongst the summaries found at Annex A of this report. One case (reference 201001670) refers to a failure identified to comply with the Disability Discrimination Act (the relevant legislation prior to the Equality Act 2010). Another relevant case (reference 201001198) refers to a failure to recognise that a patient's human rights had been engaged.

Outreach

We meet regularly with third sector organisations, holding formal seminars at least biennially, giving talks and addresses at their conferences and we also have an ongoing proactive programme of meetings with individual organisations. This enables two way discussions about the work of the office, so that we can obtain views on the service we provide from their perspective and it enables us to explain how they can help those individuals who require assistance in making a complaint to us to do so.

We have also developed a Memorandum of Understanding with the Older People's and Children's Commissioners in relation to co-operation, joint working and the exchange of information.

Equality Impact Assessments

As part of the work in developing the Strategic Equality Plan, we also developed an equality impact assessment toolkit during the past year. This will be an aid to help us identify the likely or actual effect of our policies and practices on protected groups. The toolkit will now be used each time a policy or procedure is either developed or revised.

Staff Equality Data Gathering/Monitoring - Pay and Gender

The data and information that we hold in respect of my staff is more limited. During the forthcoming year, therefore, we will revise our current arrangements for gathering employment information and pay differences so that we hold a central record. We will ask staff to complete and return a monitoring form seeking information in respect of each of the protected characteristics. I recognise, of course, that disclosure of such information by my staff will have to be on a voluntary basis.

We do, however, hold information in relation to pay and gender. Under the specific duties I am required to set an equality objective for gender and pay; if I do not do so, I must explain why. My Strategic Equality Plan does not currently contain any specific objective in this regard because as the table below shows females are very well represented at the higher pay scales within my office. However, I will ensure that this situation is kept under continual review and revise my equality objectives if necessary.

Employment equality data as of 31/03/2012

Pay (FTE)	Male	Female
under £10,000	0	0
£10,000 to £19,999	0	7
£20,000 to £29,999	0	10
£30,000 to £39,999	5	11
£40,000 to £49,999	6	9
£50,000 to £59,999	1	4
£60,000 +		1
Subtotal	**12**	**42**
Total Individuals	**54**	

Contract Type	Male	Female
Permanent	12	40
Fixed term	0	2
Subtotal	**12**	**42**
Total	**54**	

Working Patterns	Male	Female
Full Time	11	39
Part Time	1	3
Subtotal	**12**	**42**
Total	**54**	

Annex A

Public Body Complaints
Public Interest Reports: Case Summaries

Health

Cwm Taf Local Health Board
Case reference 200700602 – Report issued March 2012

Mrs R complained to me about the manner in which the former Pontypridd and Rhondda NHS Trust dealt with a complaint she made about care provided to her late mother, Mrs T. Mrs R was specifically concerned about the manner in which the Chief Executive of the Trust had responded to her about the treatment provided to her mother without declaring that the Chief Executive was married to a consultant surgeon who had been involved in the events about which she had complained to the Health Board.

My investigation found that the Chief Executive did fail to declare the fact that she was married to the Consultant when she responded to Mrs R's complaint. It also became evident to me that the Consultant in question had been significantly involved in one of the surgical procedures that Mrs T underwent and about which Mrs R complained. He also found that the former Trust's policy was that the Chief Executive should respond to all complaints letters although there was clearly provision for this function to be performed by the Deputy Chief Executive of the Trust. I found the failure of the former Chief Executive to declare her connection with the Consultant to have led to a perception by Mrs R of a conflict of interest and accordingly I upheld the complaint. In doing so I emphasised that I had seen no evidence to suggest that the Chief Executive had any influence on the content of the response letters sent to Mrs R.

Cwm Taf Local Health Board
Case reference 201002624 – Report issued March 2012

Mrs A's daughter, Sarah, was born with severe developmental delay and throughout her life had complex health care needs. Mrs A complained to me about Sarah's treatment and care at the Royal Glamorgan Hospital upon her transition from children's to adult hospital care. Mrs A said that during Sarah's only admission to an adult hospital ward, there were unacceptable delays in administering the appropriate antibiotic medication and that staff were not trained or equipped to meet Sarah's needs because of a lack of co-ordination between services during the transfer of her care. Sadly, Sarah died in hospital on 21 October 2009, aged 20. Mrs A believed that the outcome of her final hospital admission would have been different had Sarah's treatment and care been satisfactory.

I found that arrangements for Sarah's transfer of hospital care were inadequate. There was no evidence either of a clear, co-ordinated transfer process or of an effective hand over of care. The Health Board also failed to plan and deliver services in a way that recognised Sarah's individual needs in accordance with the equalities legislation. Whilst I did not find that the poor transition arrangements contributed to any clinical failing, there was some evidence that the quality of Sarah's care was compromised as a result. I also found that aspects of Sarah's clinical treatment fell below a reasonable standard; the most significant of which were the failure to initiate treatment with intravenous antibiotics within four hours of Sarah's admission to hospital and a further delay of more than 21 hours during which two doses of

prescribed oral antibiotics were not given. I was unable to say whether or not the outcome would have been different for Sarah but for those clinical failings. Finally, the investigation identified that there were inadequacies in the Health Board's handling of Mrs A's complaint.

I upheld each element of Mrs A's complaint and made a number of recommendations to the Health Board for further action to address the failings identified. The Health Board agreed to implement the recommendations and to apologise and make a redress payment to Mrs A of £2000 in recognition of the failings in her daughter's care and the resulting uncertainty over the sad outcome.

Welsh Ambulance Services NHS Trust
Case references 201002432 & 201002552 – Report issued March 2012

I received two separate complaints from Mr F and Mrs B who respectively complained about the care provided to their father and husband by the Welsh Ambulance Services NHS Trust. Both complained about the length of time it took for an ambulance to attend following the 999 calls they made to the service. They also complained about the manner in which the Trust had dealt with their complaints.

I found that ambulances and rapid response vehicles from other divisions of the service could have been deployed to both incidents, and they might have arrived with the patients sooner, but that their deployment had been overlooked. I was also critical of the quality of the Trust's investigations into Mr F and Mrs B's complaints, the content of its responses and the time it took to provide them. I upheld both complaints in full. I made a total of nine recommendations including that the Trust apologise to Mr F, Mrs B and their respective families and to pay them appropriate redress. I also recommended that the Trust should reinvestigate or review the original complaint; review the relevant policies and procedures and its management of resources and audit any changes it has implemented.

Betsi Cadwaladr University Health Board
Case reference 201001167 - Report issued October 2011

Mrs W complained about the care and treatment her husband, Mr W, received whilst a patient at Ysbyty Gwynedd (the Hospital). Mr W had been admitted to the Hospital for treatment due to dysphagia (swallowing difficulties) experienced when eating and drinking. He was discharged but was readmitted four days later due to worsening dysphagia. Mrs W complained that there was a very poor standard of care provided to her husband during his admissions which led to deterioration in his condition and, ultimately, contributed to his death. Mrs W complained about the following:

- that a procedure to stretch Mr W's gullet did not go ahead as planned due to a nursing staff error;
- that her husband was discharged without having this surgery and once readmitted, due to his declining health, he was too weak to have the procedure carried out;
- that there was a delay in obtaining a second opinion on her husband's condition and arranging a transfer to a specialist hospital.

I upheld the majority of Mrs W's complaints. I found that the clinical care provided to Mr W was inadequate as it was insufficiently intensive and lacked input from his consultant physician. I found that there were a number of clinical failings which contributed to the health problems that emerged during Mr W's readmission. The most significant of these was the decision to discharge Mr W from the Hospital's care without carrying out an oesophageal dilatation (a procedure to stretch the gullet) and the delay in raising its concerns regarding Mr W's deteriorating condition with a specialist hospital. I found that whilst the errors identified were significant, there was no definitive evidence to conclude that the ultimate tragic outcome could have been avoided but for those errors. Finally, I found that in general, the nursing care and management of Mr W was reasonable. However, inadequacies in some of the nursing records prevented a definitive conclusion from being reached in respect of the adequacy of care delivered when the tubing attached to his chest drain became disconnected.

I recommended that the Health Board should reflect on the failings in the care identified and provide confirmation of the further action taken to address the inadequacies in its staff awareness of national guidelines in relation to oesophageal dilatation, the Hospital's transfer procedures for critically ill patients, the availability of medical cover over Bank Holiday weekend periods and the insertion of chest drains. I recommended that a payment of £500 be provided to Mrs W in recognition of the time and trouble in pursuing her complaint together with a full apology for the shortcomings in the care provided to Mr W and for the Health Board's failure to recognise these failings sooner.

Abertawe Bro Morgannwg University Health Board
Case reference 201001670 – Report issued September 2011

Mrs A and Mr B complained about the Abertawe Bro Morgannwg University Health Board ("the UHB") in relation to the care provided to their brother Paul in hospital during late 2008/early 2009.

They explained that Paul had severe learning disabilities. He had been admitted to hospital for a serious bowel problem. Surgeons operated on Paul soon after his admittance. Paul sadly died in hospital about three weeks later due to respiratory problems involving excess secretions in his bronchial airways.

Mrs A and Mr B complained about many aspects of Paul's nursing and clinical care. They provided papers which showed that the nursing care had been strongly criticised in a Protection of Vulnerable Adults ("POVA") investigation run by the former NHS Trust. However, they remained unconvinced that the resulting action plan was adequate. Moreover, they considered that the investigation had not focussed on clinical care. Their main clinical concerns were that Paul had contracted pneumonia whilst in the Intensive Therapy Unit ("ITU"), been transferred prematurely to a general ward ("the Ward") and that his care on the Ward in the days leading to his tragic death was poor.

My investigation did not focus on nursing care, as the POVA process had been thorough in that regard. However, I found that Paul's nursing care on the Ward had been very poor and when combined with his clinical care, had produced an unacceptable level of treatment. With regard to Paul's clinical care, I did not agree with every aspect of Mrs A and Mr B's complaint. However, I concluded that the clinical care was generally well below a reasonable standard. In the investigation, I found that there was:

- a lack of outreach support to the Ward from the ITU;
- an over reliance on the assumption that Paul's symptoms were psychological rather than clinical;
- a lack of involvement of the consultant in charge of Paul's care;
- a failure to supervise junior doctors;
- inadequate examinations of Paul;
- failure to ensure that vital suctioning care was provided; and,
- an inability among doctors to notice that nurses were not recording Paul's observations properly.

I also concluded that the hospital had failed to comply with the provisions of the Disability Discrimination Act regarding Paul, primarily by not making reasonable adjustments to its service to cater for his special needs. I strongly upheld the main aspect of the complaint, concerning Paul's clinical care. Finally, I stated that my view was that reasonable nursing and clinical care might have altered the outcome for Paul, although this was uncertain.

I made a number of recommendations. These included a payment of £1500 to both Mrs A and Mr B for the uncertainty that they have to endure over whether Paul may have survived with adequate care. I recommended learning disability awareness training for staff; many reminders for staff about appropriate care; and relevant audits and inspections. I also recommended that the matter be discussed at a full meeting of the UHB with regard to how it can best ensure that it complies with the Equality Act. The UHB agreed to implement the recommendations.

Aneurin Bevan Health Board
Case reference 201000903 - Report issued September 2011

Mrs Q complained about the care and treatment that her mother, Mrs F, received whilst a patient at Ystrad Mynach Hospital (the hospital). Mrs F had been admitted to the hospital for assessment due to deterioration in her mental health. Mrs Q complained that her mother received a very poor standard of care during her admission which led to a more rapid deterioration in her mental and physical condition and, ultimately, contributed to her death.

Mrs Q complained about the following:

- that the family's requests for medical intervention and a transfer to a medical ward were ignored despite signs of Deep Vein Thrombosis (DVT) and deterioration in her condition during the weekend of her passing away;
- that the standards of personal care provided to Mrs F were poor and that Mrs F lost considerable weight during her admission to the hospital; and,
- that the communication with her and Mrs F's family and the information provided about her care plan were grossly inadequate.

I upheld the majority of Mrs Q's complaints. I found that the hospital's procedures for the earlier detection of DVT in a patient displaying potential symptoms were lacking. I also found that the staff failed to act in an appropriate manner and contact a doctor for a medical opinion following the deterioration in Mrs F's condition. The hospital also failed to seek or provide adequate reasons why access to a doctor over the weekend period was not available. I found that, in general, the overall record keeping for the period of Mrs F's admission was extremely poor. This had led to inadequacies in the response provided to the family during the internal complaints process and also in the proposed Action Plan implemented by Aneurin Bevan Health Board (the Health Board) to address the family's concerns. Finally, I found that the standard of care and treatment provided to Mrs F during her admission fell below a reasonable standard. There was no evidence that Mrs F's personal hygiene or nutritional needs were being met or that the care plans were implemented.

I recommended that the Health Board should reflect on the failings identified and provide confirmation of the further action taken to address the inadequacies in the hospital's procedures and operational policies, to improve its staff awareness of DVT and to ensure that early detection is promoted, to ensure that its staff recognise deterioration in a patient's condition, to provide adequate medical cover support to its nursing staff and a clear pathway for referral of patients with medical needs and also to review the availability of medical cover on the ward including out of hours and weekend cover. I also recommended that an apology be provided for the shortcomings in the care provided to Mrs F and for its failure to act more promptly in light of the family's concerns.

Cwm Taf Health Board
Case reference 201001569 - Report issued August 2011

Mrs D complained about the treatment her late father, Mr A, received at the Royal Glamorgan Hospital ("the Hospital") in 2007 and 2008. At that time, the Hospital was the responsibility of the former Cwm Taf NHS Trust ("the Trust"). Due to NHS re-organisation in Wales during 2009, the obligations of the former Trust now lie with the Cwm Taf Local Health Board ("the LHB"). Mrs D said that the Hospital did not properly investigate, diagnose or treat Mr A, during two admissions in late 2007 and early 2008. The admissions were soon after Mr A had received successful surgery and radiotherapy to treat a rectal tumour. They resulted from general but undiagnosed ill health. Mr A sadly died in January 2008, whilst in the Hospital, due to shock caused mainly by a gastric ulcer. Mrs D stated that the Hospital did not diagnose that Mr A had a pelvic abscess during his first admission, noting that his post mortem concluded that this was a contributory factor in his death. She maintained that during the second admission, the gastric ulcer should have been identified and treated. She also complained that a drug had not been administered properly. Mrs D also expressed dissatisfaction with the Trust's complaint handling. She asserted that the former Chief Executive should not have signed the complaint response, as a clinician involved in Mr A's care was a close relative of hers. Mrs D also said that the Trust's complaint response to her mother did not deal with all the issues.

I did not uphold the complaint about the first admission. However, I found serious failings with regard to the second admission. I found that there was no systematic approach to diagnosing Mr A's condition, no plan about when clinical reviews should take place and no decision made about the frequency that nursing staff should record observations for Mr A. In the event, a doctor did not review Mr A the day before his death and observations were not sufficient or carried out properly. Had those failings not occurred, the problem with Mr A's undiagnosed gastric ulcer might have come to light. I concluded that there was a chance that had that happened, the sad outcome might have been different. I also found that Mrs D was right about the poor administration of a drug. I concluded that the former Chief Executive should not have signed the complaint response without informing the family of the connection between her and a clinician who had been involved in Mr A's care, even though that clinician was not criticised in his report.

I made numerous recommendations to the LHB, which it has accepted. These included paying £1500 to Mrs D as an acknowledgement of the uncertainty she has to live with concerning whether her father might have survived the episode with better care; providing evidence that effective systems are in place regarding nursing observations; carrying out an audit to ensure that patients requiring daily clinical reviews are receiving them; and introducing a written conflict of interest policy.

Hywel Dda Health Board
Case reference 201002404 - Report issued August 2011

Ms P complained that her late mother, Mrs P, was inappropriately discharged home from Bronglais Hospital in Aberystwyth in February 2008; that communication with her about her mother's condition was poor; and that the Health Board did not robustly investigate her complaints or provide her with a reasonable and timely response. Sadly, Mrs P died within hours of being discharged home.

I found that Mrs P had suffered marked falls in her oxygen saturations (a measure of respiration efficiency) during the two nights before she was discharged. While the first fall was reported to the doctors the next day, there was no evidence that they were notified of the second fall, or that other abnormalities in Mrs P's pulse and blood pressure were recognised or acted on.

I concluded that given Mrs P's abnormal observations, she should not have been discharged when she was. I also found that communication with Ms P about her mother's condition was poor, in part because of the failure to recognise the abnormal observations. I upheld these parts of Ms P's complaint.

Turning to the handling of Ms P's complaint, I was concerned that the process became protracted, and that there were some unavoidable delays. I also noted that the Health Board's internal investigations had not identified any concerns about the lack of response to Mrs P's abnormal observations. I also upheld this complaint.

I recommended that the Health Board apologise to Ms P and pay her £100 in recognition of the time and trouble she had been put to in pursuing her complaint. I also made recommendations aimed at improving responses to abnormal observations and record keeping on the ward concerned. The Health Board has agreed to implement my recommendations.

Hywel Dda Health Board
Case reference 201000665 - Report issued June 2011

Mr C complained about his follow-up care from the Health Board after he had been diagnosed with cancer of the prostate. His active monitoring treatment plan ought to have involved 3 monthly check-up appointments from November 2008, with a repeat biopsy at 12 months. He said that he received no follow-up appointment until over a year later (when he enquired about the biopsy appointment in December 2009). When seen, his cancer had advanced. Mr C complained that a timely appointment would have meant the cancer's advancement being noticed earlier and an active treatment regime would have begun sooner. He was dissatisfied with the Health Board's response to his complaint feeling no adequate explanation had been given about the lack of follow-up care.

The investigation uncovered serious failures, including that the Health Board's Urology service at the relevant time had an appointment backlog of over 11 months; no effective or urgent action was taken to address the increasing backlog within that time; there were no written procedures for appointment making which was a function of the medical records department; ineffective liaison between the medical records department and clinical staff with no system of prioritising those patients in need of urgent follow-up appointments (such as Mr C who had a cancer diagnosis requiring close monitoring); and a consequential breach of NICE clinical guidance.

All the shortcomings had severe consequences for Mr C. I was very critical of these fundamental failings which I felt called into question the Health Board's governance and potentially placed more patients at risk. In addition to making the circumstances known to Health Inspectorate Wales to monitor the Health Board's future appointment arrangements, I made a number of recommendations, including: an apology and redress of £3000 to Mr C for the failures and distress caused to him; a review of its appointments system across all specialties; an action plan to address the issue of timely follow-up appointments; and, accompanying written procedures regarding appointment booking. The Health Board agreed to implement all the recommendations.

Housing

Isle of Anglesey County Council
Case reference 200902138 - Report issued June 2011

Ms A's complaints concerned how the Council dealt with her housing applications and the affordability of her current temporary accommodation. In early 2000, when Ms A was a private sector tenant, she applied to the Council for housing. She said that she had made a number of contacts with Housing Services over the years to try and progress her applications and had raised issues of overcrowding, disrepair and anti-social behaviour. Ms A complained about the length of time she had been waiting to be offered a Council house, particularly as the Council had accepted that it owed her a full homelessness duty in November 2004. Ms A was placed in temporary accommodation from June 2009. She complained that she was not made aware that the charge for her accommodation was likely to increase as a result of funding changes.

The investigation found serious shortcomings in the way that the Council dealt with Ms A's homelessness and housing applications. Although the Council accepted that it had a homelessness duty towards Ms A, there was no evidence that she was formally offered temporary accommodation before June 2009. The Council subsequently misfiled her homelessness application and it was not progressed for a period of four and a half years. In addition, the Council repeatedly failed to consider all of the available information relevant to Ms A's housing applications in accordance with its Allocations Policy. This led to her not being offered a Council property in September 2005. The investigation also uncovered serious deficiencies in the Council's record keeping. Whilst recognising the Council's later efforts to minimise the impact on applicants of increased charges for its temporary accommodation, I felt that the Council should have had greater regard, at an earlier stage, to its Homelessness Strategy. This was particularly relevant for working applicants who might not qualify for housing benefit. I found systemic maladministration. I recommended that the Council apologise to Ms A and her family for its failings, and offer her a redress payment of £1500. I also made a number of recommendations for further action by the Council, including the production of up-to-date written procedures on housing allocations and homelessness and further training for relevant officers.

Wrexham County Borough Council
Case reference 201002076 - Report issued February 2012

I received a complaint from Mr S about Wrexham County Borough Council ("the Council"). Mr S is a disabled single person, who lives with his mother, a council tenant. Due to mobility difficulties, generally he is confined to a bedroom at the property. He said that the bedroom is in a state of disrepair and that despite complaining about the disrepair for some time, no repairs had been done. Mr S said that his mother's council house is not adapted and is unsuitable for his needs. He complained that he had applied for housing "Over 10 years ago" yet the Council's records only show that his first application was made in July 2007. Mr S said that, as a regular wheelchair user, he has been offered properties that are unsuitable for his needs. He believed that the Council had failed to fulfil its

statutory responsibilities, as it did not appear to have a separate "Disabled Persons Housing List".

My investigation found evidence of systemic failures in the Council's approach to handling Mr S's application for housing. The Council failed to follow relevant legislation, statutory guidance and its own policies and procedures on a number of occasions. Poor record keeping compounded the failings.

I recommended that the Council should apologise to Mr S for the identified failings; pay him £1500 as redress; and thoroughly re-assesses his housing application and homelessness status. I also recommended that the Council should train all housing staff, on the recognition of homelessness and identifying when inquiries must commence. The Council should apologise to Mrs G for the delays in dealing with the disrepair and ensure that the repairs to the property are now completed.

In addition, I recommended that the Council should:

- review the Housing Department's procedures to ensure that they fully and properly reflect legislation and statutory guidance;
- review the Department's systems to ensure that it is able to match housing applications from disabled people effectively and appropriately to suitable properties;
- review the Department's record keeping methods, to ensure that the records maintained comply with the Data Protection Act; and
- review the Department's communication and information sharing mechanisms, to ensure that lessons learnt contribute to an improvement in the service provided.

Lastly, I recommended that the Council should consider adopting the Model Complaints Policy and Guidance issued by the Welsh Government in July 2011.

Carmarthenshire County Council
Case 201001198 – Report issued January 2012

Mr M complained that the Council had allocated him a property in 2008 which it subsequently stated could not be adapted to meet his needs. Mr M is disabled and the Council had been fully aware of his needs prior to allocating the property to him. The Council advised Mr M to apply for a transfer to a more suitable property, but Mr M did not wish to move again as he and his family had become settled there.

Mr M had requested internal adaptations to the property (the fitting of a stairlift and a walk-in shower), and work to improve the external access. The Council stated that the external adaptations were not feasible and would not meet Mr M's needs. It therefore carried out no adaptations to the property for over three years until it reassessed Mr M's needs following Mr M's complaint to my office in 2011. It then agreed to carry out all the adaptations requested.

I found maladministration in the allocation process and throughout Mr M's request for adaptations at the property. There had been no occupational therapy assessment of the property prior to allocation to Mr M, nor was there a full assessment of Mr M's needs for adaptations by either an occupational therapist or social services for over three years after he had moved into the property. The Council did

not appear to recognise its statutory social care duties to Mr M, or that his human rights may have been engaged. I upheld Mr M's complaint and made a number of recommendations including an apology to Mr M and a payment of £3000.

Social Services

Cardiff County Council
Case reference 201002439 – Report issued February 2012

Mrs L complained to me about the manner in which Cardiff Council handled a referral made to its social services department under Protection of Vulnerable Adults (POVA) arrangements. The referral, which was raised by hospital staff when Mrs L's husband was admitted to the hospital related to concerns about the manner in which he had been allowed to develop the most severe grade of pressure sore. Prior to admission Mr L, who suffered from MS and was bed-ridden was being cared for at home by Mrs L and his carers whilst District Nurses managed his pressure sores. Mrs L was concerned that the POVA arrangements had failed to investigate the concerns expressed and failed to investigate discrepancies in the evidence provided by district nurses at POVA meetings. She was also concerned about the manner in which the Council dealt with her complaint about the matter.

I upheld the complaint finding that the consideration of the referral by the POVA meetings was inadequate and that their findings were unsustainable and should be set aside. I also upheld Mrs L's complaint about the manner in which the Council had considered Mrs L's complaint both in terms of its timeliness and in relation to the substance of its response. I recommended redress to Mrs L in recognition of her time and trouble in pursuing her complaint. I also made a number of further recommendations to the Council; a review to ensure no other service users are at risk; an audit of referrals which accused NHS staff of abuse or neglect to ensure that these have been properly dealt with and; a reconsideration of the original investigation to correct the record and ensure that all relevant lessons have been learned.

Annex B

Public Body Complaints

Statistical Breakdown of Outcomes by Public Body Complaints Investigated

COUNTY/COUNTY BOROUGH COUNCILS

County/County Borough Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Blaenau Gwent	1	1	3		2		1			**8**
Bridgend	2	12	8		3			2		**27**
Caerphilly	6	21	20		5			1	1	**54**
Cardiff	12	32	27		8	1	9	1		**90**
Carmarthenshire	7	19	25		5	1	1	4		**62**
Ceredigion	4	10	9		2		1	2		**28**
Conwy	5	9	6		4					**24**
Denbighshire	1	17	11	1	4		2		1	**37**
Flintshire	4	13	13	2	3		1			**36**
Gwynedd	6	17	8		5		2		1	**39**
Isle of Anglesey	3	10	6	1	3	1	4	1		**29**
Merthyr Tydfil	8	1	4		3					**16**
Monmouthshire	4	20	12		1		1			**38**
Neath Port Talbot	6	19	9		1		1	1		**37**
Newport	3	5	7	2	2		1			**20**
Pembrokeshire	4	9	20		4			1		**38**
Powys	7	11	9		3		2			**32**
Rhondda Cynon Taf	4	28	16		4		2			**54**
Swansea	7	20	21		5		4		1	**58**
The Vale of Glamorgan	6	12	11	1	2					**32**
Torfaen	3	11	8	1	1			1		**25**
Wrexham	9	15	15		8	1	1	1		**50**
TOTAL	**112**	**312**	**268**	**8**	**78**	**4**	**33**	**15**	**4**	**834**

OTHER LOCAL AUTHORITY

Other Local Authority	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
National Park Authorities										
Brecon Beacons			2		1					**3**
Pembrokeshire Coast	1	2	3							**6**
Snowdonia	4	1	4							**9**
TOTAL	**5**	**3**	**9**		**1**					**18**
Schools Admissions Appeals Panels										
St. Joseph's Catholic and Anglican High School								1		**1**
Cardiff High School				1						**1**
Brynmawr Foundation School							1			**1**
Llanishen High School			1							**1**
St Joseph's Roman Catholic Infant School							1			**1**
Welshpool High School			1							**1**
Ysgol Bryn Onnen								1		**1**
Tynewydd Primary School								1		**1**
Governors of St Joseph's Cathedral Infant & Junior School							1			**1**
TOTAL			**2**	**1**			**3**	**3**		**9**
Drainage Boards										
Powysland Internal Drainage Board	1									**1**
TOTAL	**1**									**1**
OVERALL TOTAL 'OTHER LOCAL AUTHORITY'	**6**	**3**	**11**	**1**	**1**		**3**	**3**		**28**

COMMUNITY/TOWN COUNCILS

Community/Town Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Argoed Community (Flintshire)		1								**1**
Barmouth Town	1									**1**
Beaumaris Town		1								**1**
Blaenhonddan Community		1								**1**
Caerwent Community		1								**1**
Dyffryn Arth Community		2								**2**
Hirwaun Community			1							**1**
Llanddowror Community		1								**1**
Llandrindod Wells Town			1							**1**
Llandudno Town			1							**1**
Llanrhidian Higher Community		1								**1**
Llansannan Community			1							**1**
Llansteffan Community			1							**1**
Llantrisant Community		1								**1**
Llysfaen Community		1								**1**
Monmouth Town			1							**1**
Overton Community		1			1					**2**
Rogiet Community			1							**1**
St Brides Major Community			1							**1**
St Clears Town		1	1							**2**
The Havens Community		1								**1**
TOTAL	**1**	**13**	**9**		**1**					**24**

REGISTERED SOCIAL LANDLORDS

Registered Social Landlord (Housing Association)	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Bro Myrddin		2								**2**
Bron Afon Community		2	2		5					**9**
Cadwyn		1								**1**
Cardiff Community		1	1							**2**
Cartrefi Conwy	1	1			1					**3**
Cartrefi Cymunedol Gwynedd	2	2	3		1				1	**9**
Charter Housing	1	2	1		2		1			**7**
Clwyd Alun	1	2	2		1		1			**7**
Coastal Housing		1			3					**4**
Tai Eryri		1	1		1					**3**
Cynon Taf		2	2							**4**
Family Housing Association (Wales)		1	2							**3**
First Choice		1								**1**
Hafod Care		1			1					**2**
Hafod Housing		1	3		1					**5**
Linc-Cymru		1								**1**
Melin Homes		3								**3**
Merthyr Valleys Homes		2	2							**4**
Monmouthshire		3			2					**5**

REGISTERED SOCIAL LANDLORDS (continued)

Registered Social Landlord (Housing Association)	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Newport City Homes		2	2		2					**6**
NPT Homes		2	1							**3**
RCT Homes		3	2		2					**7**
Rhondda Cynon Taf Care and Repair		1								**1**
Rhondda			1							**1**
Tai Calon	1		1							**2**
Tai Ceredigion		2								**2**
United Welsh					1					**1**
Valleys to Coast	1	2	1		1					**5**
Wales and West	1	8	5							**14**
YMCA Cardiff			1							**1**
TOTAL	**8**	**50**	**33**		**24**		**2**		**1**	**118**

NHS TRUSTS AND LOCAL HEALTH BOARDS

LHB/Trust	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abertawe Bro Morgannwg University Health Board	2	20	12	1	9	1	8	6	1	**60**
Aneurin Bevan Health Board	2	16	20		6	1	9	4	1	**59**
Betsi Cadwaladr	7	21	21	1	21	1	11	7	2	**92**
Cardiff and Vale University HB	1	21	13		10		12	6	1	**64**
Cwm Taf	2	14	5	1	1	3	4	3	1	**34**
Hywel Dda	1	19	14	1	9	2	3	3	1	**53**
Powys	1	2	4	4	2		1	2		**16**
Public Health Wales		1	1							**2**
Velindre NHS Trust			3							**3**
Welsh Ambulance Services NHS Trust	1	2	4			2	4			**13**
TOTAL	**17**	**116**	**97**	**8**	**58**	**10**	**52**	**31**	**7**	**396**

OTHER HEALTH BODIES

Health Body	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Dentist	1	6	7	1	3		1	1	1	**21**
GP	3	6	15		4		12	8	2	**50**
Community Health Council - Betsi Cadwaladr		1								**1**
Optician		1								**1**
Pharmicist								1		**1**
TOTAL	**4**	**14**	**22**	**1**	**7**		**13**	**10**	**3**	**74**

WELSH GOVERNMENT AND WELSH GOVERNMENT SPONSORED BODIES

Welsh Government and Welsh Government Sponsored Bodies	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Welsh Government										
CAFCASS	1	6	8		2					**17**
CSSIW		1	1	1	1					**4**
Health Commission Wales			1							**1**
Independent Complaints Secretariat									1	**1**
Independent Review Secretariat			1							**1**
Mid Wales Trunk Road Agency		1								**1**
Planning Inspectorate	1	3	4							**8**
Welsh Government	6	7	8		3					**24**
Welsh Health Specialised Services Committee							1			**1**
TOTAL	**8**	**18**	**23**	**1**	**6**		**1**		**1**	**58**
Welsh Government Sponsored Bodies										
Care Council for Wales		1								**1**
Countryside Council for Wales	1							1		**2**
Higher Education Funding Council for Wales (HEFCW)			1							**1**
TOTAL	**1**	**1**	**1**					**1**		**4**
OVERALL TOTAL WELSH GOVERNMENT AND ITS SPONSORED BODIES	**9**	**19**	**24**	**1**	**6**		**1**	**1**	**1**	**62**

OTHER

Other	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Environment Agency		3	1							**4**
ESTYN	1									**1**
Residential Property Tribunal for Wales	1				1					**2**
National Clinical Assessment Service (NCAS)	1									**1**
Body not in jurisdiction - not previously decided	3									**3**
TOTAL	**6**	**3**	**1**		**1**					**11**

Annex C

Code of Conduct Complaints: Statistical Breakdown of Outcomes by Local Authority

COUNTY/COUNTY BOROUGH COUNCILS

County/County Borough Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Blaenau Gwent	4		1					**5**
Bridgend	3							**3**
Caerphilly	6	1		1				**8**
Cardiff	5			1				**6**
Carmarthenshire	7						1	**8**
Ceredigion	4							**4**
Conwy	9							**9**
Denbighshire	5			1	1	1	1	**9**
Flintshire	8			2			1	**11**
Gwynedd	2							**2**
Isle of Anglesey				1	2	1		**4**
Merthyr Tydfil	3							**3**
Monmouthshire	7							**7**
Neath Port Talbot	1							**1**
Newport	2			1				**3**
Pembrokeshire	7			1				**8**
Powys	5		1					**6**
Rhondda Cynon Taf	8				1		1	**10**
Swansea	38	1					2	**41**
The Vale of Glamorgan	12							**12**
Torfaen	5			1		1		**7**
Wrexham	1							**1**
TOTAL	**142**	**2**	**2**	**9**	**4**	**3**	**6**	**168**

COMMUNITY/ TOWN COUNCILS

Community/Town Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Blackwood Town	1							**1**
Brecon Town	1							**1**
Buckley Town					3			**3**
Caernarfon Royal Town	2						1	**3**
Caerphillly Town	1							**1**
Clydach Community	3							**3**
Coedpoeth Community						1		**1**
Cwmllynfell Community	1							**1**
Dyffryn Ardudwy a Thalybont Community	1							**1**
Dyffryn Arth Community	1							**1**
Forden Community	1							**1**
Gorseinon Town	2							**2**
Gwersyllt Community	1							**1**
Holyhead Town	1							**1**
Kidwelly Town				3				**3**
Laleston Community	1							**1**
Llanddulas and Rhyd y Foel Community			1					**1**
Llandegla Community	3							**3**
Llandrindod Wells Town	2							**2**
Llanedi Community	2							**2**
Llanfair (Gwynedd) Community	1							**1**
Llanfair Mathafarn Eithaf Community	1							**1**
Llangynwyd Lower Community	2						3	**5**
Llanidloes Without Community	1							**1**
Llay Community				1				**1**

COMMUNITY/ TOWN COUNCILS (continued)

Community/Town Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Maesteg Town	1							**1**
Magor with Undy Community	1							**1**
Manorbier Community	6		1					**7**
Mold Town	1							**1**
Mumbles Community	3				1		1	**5**
Newtown & Llanllwchaiarn Town	3							**3**
Pelenna Community				1				**1**
Penmaenmawr Town	3							**3**
Penmynydd and Star Community	2						1	**3**
Pentyrch Community					1			**1**
Porthcawl Town				2				**2**
Prestatyn Town	28	4	3	2				**37**
Pyle Community		2			6			**8**
Rhyl Town	1	1		8				**10**
Ruthin Town	1							**1**
Saltney Town	1							**1**
Seven Sisters Community	1							**1**
Shotton Town	1							**1**
St Arvans Community	2							**2**
St Brides Major Community	1							**1**
St Harmon Community	9							**9**
Sully Community				1				**1**
Towyn & Kinmel Bay Town	3							**3**
Trellech United Community	1							**1**
Wick Community	7			1				**8**
Ystrad Fflur Community	1							**1**
Ystrad Meurig	1							**1**
TOTAL	**107**	**7**	**5**	**19**	**11**	**1**	**6**	**156**

NATIONAL PARK AUTHORITIES

National Park Authority	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Brecon Beacons	2							**2**
Pembrokeshire	16							**16**
Snowdonia	3							**3**
TOTAL	**21**							**21**

Annex D

Extract from Strategic Plan 2009/10 to 2011/12
Vision, Values, Purposes and Strategic Aims

Our vision

- To contribute to the development of excellent public services in Wales by ensuring that service providers continue to value and learn from complaints.

Our values

- **Accessibility** – to be open to everyone from all of our communities and work to ensure that people who face challenges in access are not excluded. We will be courteous, respectful and approachable, and communicate with complainants in the way they tell us they prefer.
- **Excellence** – to be professional and authoritative in all that we do and promote excellence in the services with which we work
- **Learning** – we believe that we should improve through learning from our own experiences and should help others to learn from theirs
- **Fairness** – we will maintain our independence and reach decisions objectively having carefully considered the facts
- **Effectiveness** – we will make sure that we use resources to secure best value for the public purse
- **Being good employers** – we will continue to invest in our well trained and well motivated staff.

Our Purposes

- To consider complaints about public bodies
- To consider complaints that members of local authorities have broken the code of conduct
- To put things right – we aim to put people back in the position they would have been in if they had not suffered an injustice, and work to secure the best possible outcome where injustice has occurred
- To recognise and share good practice
- To work with public bodies so that lessons from our investigations are learnt
- To ensure continued improvement in the standards of public services in Wales by helping bodies to get it right first time – we will work to reduce complaints by helping service providers to improve their initial decision making.

Strategic Aims

Strategic Aim 1: To raise awareness of our service so that people understand what we do, and that all who need it can access it and make use of it.

Strategic Aim 2: To have in place high quality complaints handling processes, which consider and determine complaints thoroughly but proportionately, and convey decisions clearly.

Strategic Aim 3: To work with public bodies in Wales so that better quality public services are provided as a result of the lessons that can be learnt from the complaints we investigate.

Strategic Aim 4: To demonstrate that our resources are efficiently and effectively deployed.

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