Ombudsman

PUBLIC SERVICES OMBUDSMAN FOR WALES

QUALITY AND PERFORMANCE

ANNUAL **REPORT** 2010/11

The Annual Report 2010/11

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 third, annual report since taking up my post as Ombudsman and the fifth annual report of the Public Services Ombudsman for Wales following the introduction of the office in 2006.

Two years into the current three year strategic plan, I am very encouraged by the progress we have made. We are now beginning to realise the rewards of the changes we began introducing a couple of years ago and we are now fleeter of foot in the way we deal with our casework. I am extremely pleased that we have been able to cut dramatically the backlog of cases caused by a surge in demand and, in particular, with the high number of investigation reports that we issued during the course of this year.

Nevertheless, whilst our complaint handling processes are leaner, we have not lost focus on the importance of quality. We have been keen to identify complaints that lend themselves to resolution without the need to resort to full investigation and examples of such cases can be found in this report. However, we have also been resolute in ensuring that the more complex cases –almost invariably about health or social care issues – receive the detailed, in-depth investigation that they deserve.

Complaints about local authorities have remained fairly stable over the past couple of years, however, health complaints continue to rise (up 10% on last year) and now account for a quarter of the complaints that I receive about public service providers. I expect this increase to continue as a result of the demise of the independent review stage in the health complaints procedure resulting from the NHS Redress Measure. However, equally, I hope the rise will be tempered as a result of Health Boards making a commitment to putting things right at the local level in line with the new redress arrangements, avoiding complaints having to be escalated to me.

In the introduction to my report last year, I referred to the considerable increase in complaints about the conduct of local authority members and my hope that councillors would take on board the advice and direction in the Guidance I would be issuing in April 2010. It has been pleasing to see, therefore, a significant decline (down 21%) in the number of new complaints received this year.

There are two areas where I believe there are anomalies in relation to my jurisdiction. Increasingly, I have been receiving enquiries from residents in care homes (or members of their family) who wish to complain to me but cannot do so because their care is self-funded. I believe this increase has arisen due to the publicity surrounding the changes recently introduced in England in respect of the Local Government Ombudsman. Currently in Wales, 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 care home cannot. It seems to me unjust that residents in the same care home receiving the same services do not have the same rights in relation to seeking redress when things have gone wrong.

The other anomalous area, one which received wide media attention following a report that I issued in March 2011, is that I have no jurisdiction to look into complaints about hospices. Whilst such private hospitals are registered charities, they do nevertheless receive public funding. Currently, service users have no recourse to complain beyond the hospice itself. I believe it to be only right that people in receipt of their services have recourse for an independent body to consider their complaint.

I, therefore, look forward to discussing these two issues with the new Welsh Government in the forthcoming year.

Finally, I would like to pay tribute to my staff. They are a highly skilful and effective team. I set an extremely ambitious target when I gave a public undertaking that by 31 March 2011 we would have no cases open older than 12 months old. Achieving this was a true team effort and they should be extremely proud of their achievement. Having arrived at this position, I am satisfied we are now well placed to deal with the anticipated increase in complaints, both as a result of the implementation of the NHS Redress Measure from 1 April 2011 and the pressures being faced by public services in Wales due to the financial constraints upon them in forthcoming years. All this has been accomplished whilst also preparing for the introduction of the new Complaints Wales signposting service, developing an upgraded version of our case handling system and new websites, together with the introduction of new activities such as the Ombudsman's Casebook and Annual Letters.

Peter Tyndall
Ombudsman

2. The Role of the Public Services Ombudsman for Wales

The Public Services 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 Assembly 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. There have been ten 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 the number of cases settled in this way this year, and I hope that this will increase further now that the Complaints Advice Team is in place (see page 15 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 1,127 enquiries, **up 49%** on 2009/10
- We received 1,425 new complaints, **up 3%** on 2009/10
- We achieved 120 quick fixes/voluntary settlements, **up 33%** on 2009/10
- We issued 315 investigation reports, **up 54%** on 2009/10.
- We closed 1,634 cases, **up 13%** on 2009/10
- Number of cases on hand at 31 March 2011 was 295 cases, **a reduction of 48%** on 2009/10.
- We had no investigations older than 12 months old open at 31 March 2011

Caseload – overall position

I reported last year that for the first time since the PSOW office came into existence, the number of complaints about maladministration or service failure fell. However, this past year, complaints have increased again. As the figures in the table below indicate, the overall level of complaints about public bodies has increased by 3% compared to the position for 2009/10.

	Total Number of Complaints
Cases carried over from 2008/09	585
Cases reopened in 2009/10	26*
New cases 2009/10	1,381
Total complaints 2009/10	**1,992**
Cases carried over from 2009/10	563
Cases reopened in 2010/11	6*
New cases 2010/11	1,425
Total complaints 2010/11	**1,994**
Cases to be carried forward to 2011/12	**295**

** A small number of cases are reopened from one year to another due to further information having been received from the complainant subsequent to closure.*

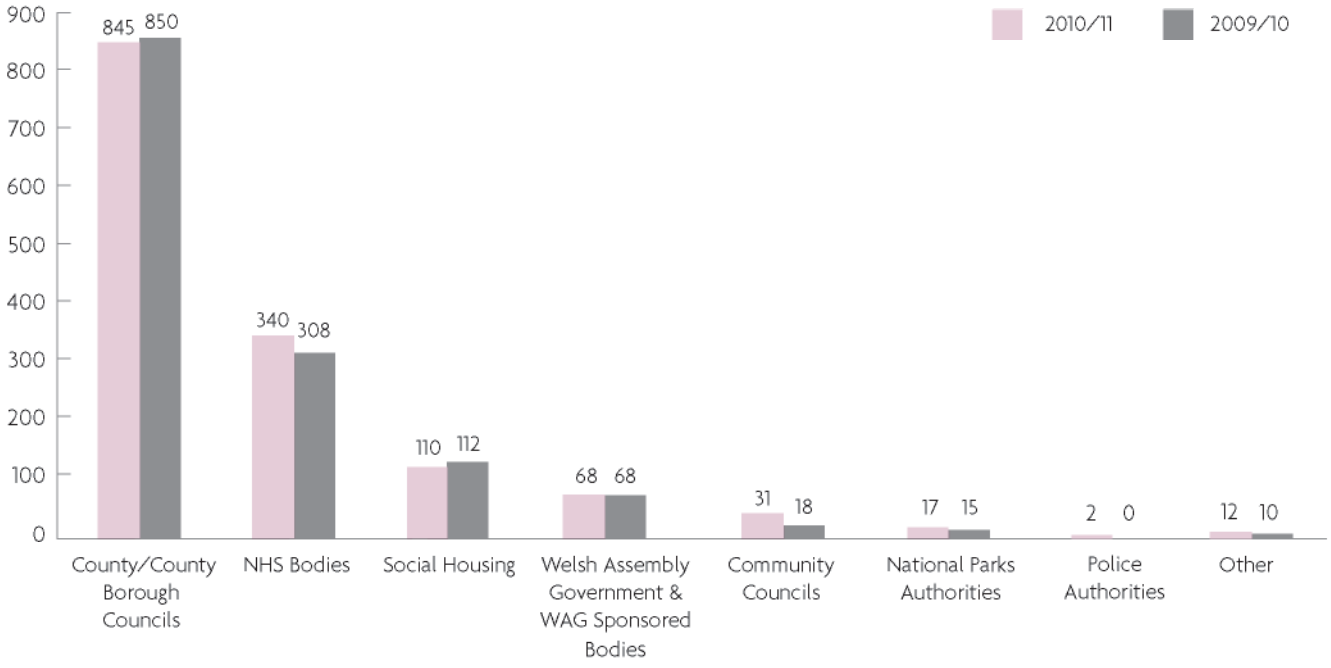
In addition, the office dealt with 1,127 enquiries during 2010/11, compared with 754 last year.

Those who take an interest in my Annual Reports may recall my concern over the past couple of years about the effect that year on year increases in complaints were having on the number of cases being carried forward from one year to another. I am extremely pleased, therefore, that we have managed to cut this by almost a half, from 563 at end 2009/10 to 295 at the end of 2010/11.

Sectoral breakdown of complaints

The pattern of previous years is that the vast majority of complaints received are in respect of county councils. As the chart below shows, this continues to be the case and is to be expected given they are direct providers of a wide range of services to the public. However, on a positive note and particularly given the financial pressures faced by authorities, it is pleasing that the level of complaints about county councils has remained steady (845 complaints in 2010/11 compared with 850 the previous year). The same can also be said about the situation in relation to registered social landlords (110 compared to 112 in 2009/10) and also of other sectors, including community councils and the Welsh Assembly Government. The exception to this trend is the NHS (340 compared to 308 in 2009/10).

Complaints by public body sector

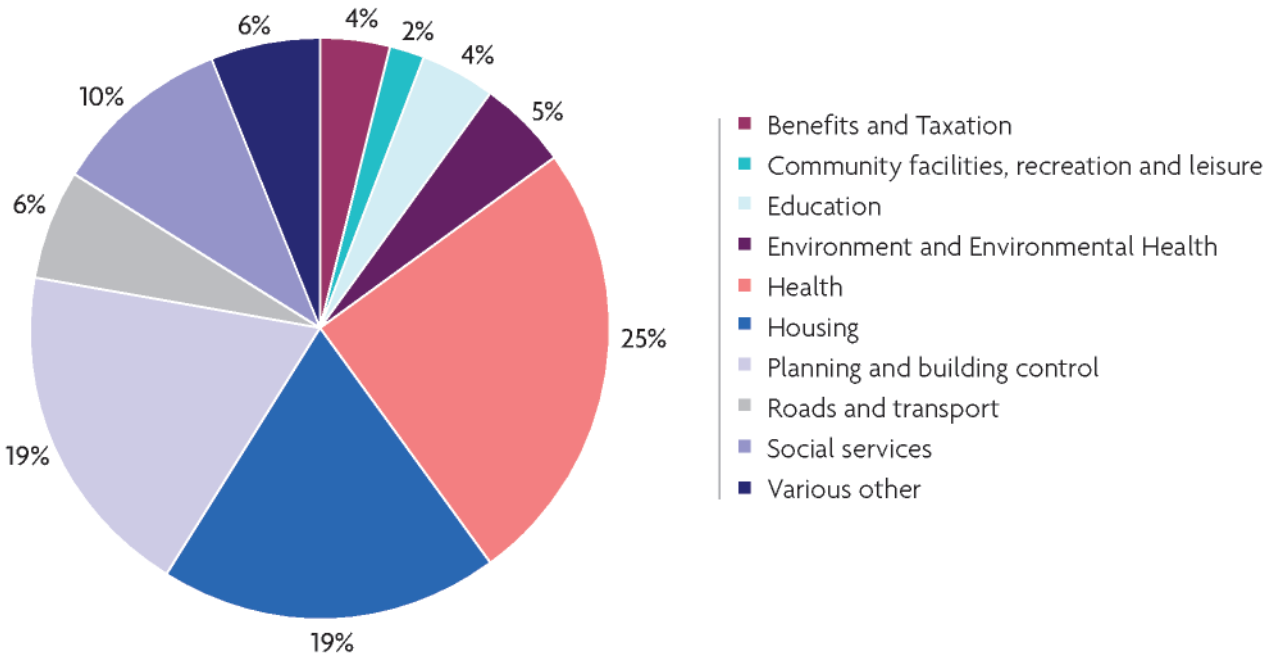


Complaints about public bodies by subject

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. In fact, there has been a 70% increase in such complaints since the office of PSOW came into existence in April 2006. As can be seen from the chart below, health now accounts for 25% of the caseload (this was 23% in 2009/10). Housing and Planning are the next largest areas of complaint, each accounting for 19% of the complaints received.

It is a matter of concern that the number of complaints in respect of NHS bodies and health matters continues to rise. With the introduction of the NHS Redress Measure in April 2011, I hope that NHS bodies will themselves be more effective in handling the concerns and complaints presented to them by service users. However, the Measure also abolishes the Independent Review process, allowing all those complainants remaining unhappy at the end of the NHS process to come directly to my office for an independent consideration of their grievance. I therefore, expect that the number of health complaints that my office receives will continue to rise.

Complaints by subject



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. I referred in my report last year to the fact that we introduced changes with a view to being better able to cope with the volume of casework being received by the office. I was pleased, to report that we achieved an increase in the number of cases closed over the past year compared to 2009/10.

It is very pleasing to be able to report this year that we have improved even further on this with the level of cases closed during 2010/11 having increased considerably on last year (up by 13%). Remarkably though, we issued 315 investigation reports as opposed to 205 last year (this is a 54% increase).

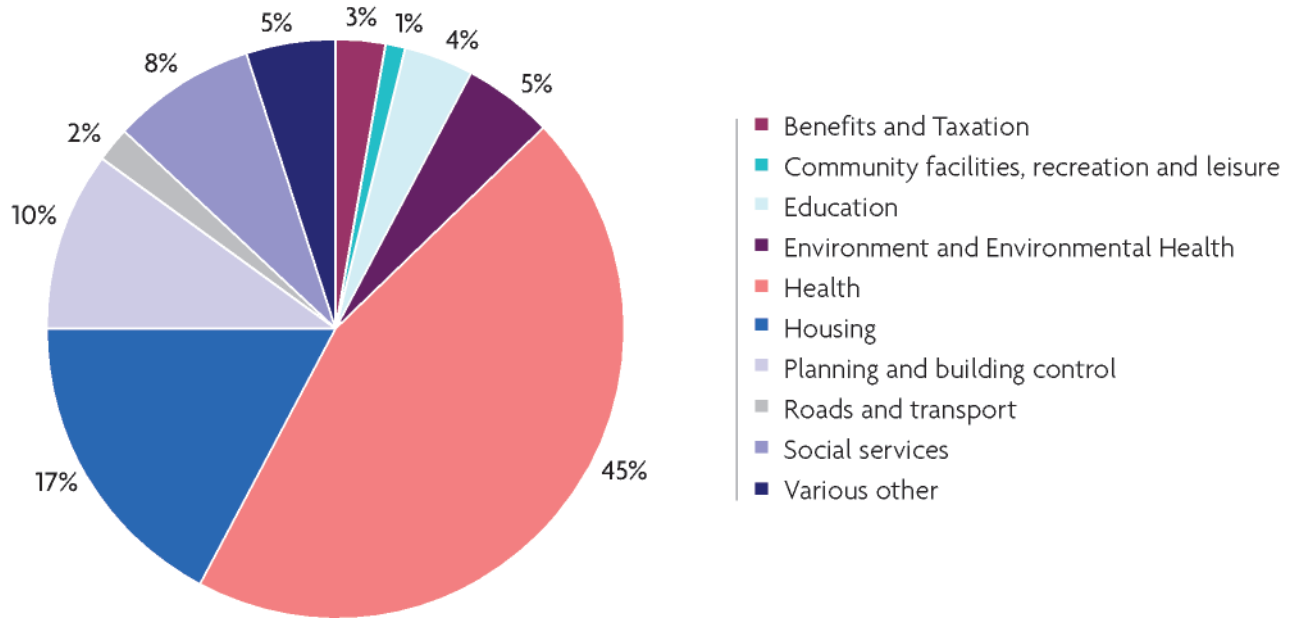
The number of complaints resolved by a 'quick fix' or upheld following investigation was higher (totalling 331 compared with 241 in 2009/10). Of those 331 cases, it is striking that health complaints accounted for 149 of these outcomes (see chart below).

(A breakdown by listed authority of the outcome of complaints investigated during 2010/11 is set out at Annex B.).

Complaint about a Public Body	**2010/11**	**2009/10**
Decision not to investigate	1,113	893
Complaint withdrawn	48	67
Complaint settled voluntarily (including "quick fix")	120	90
Investigation discontinued	38	187
Investigation: complaint not upheld	104	54
Investigation: complaint upheld in whole or in part	198	136
Investigation: complaint upheld in whole or in part – public interest report	13	15
Total Outcomes – Complaints	**1,634**	**1,442**

Proportion by subject of quick fix/upheld cases

As the chart below shows where some form of redress took place, 45% of these related to health cases and of those health cases almost one third were resolved via a quick fix.



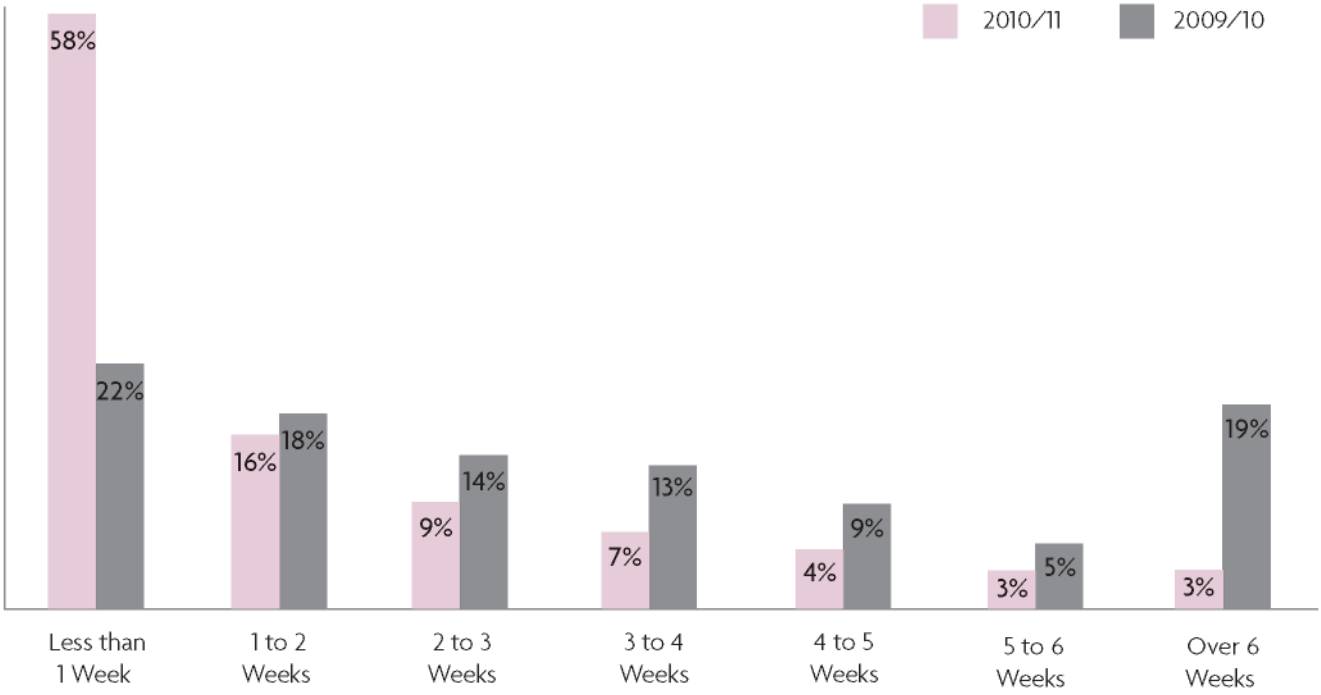
Decision times

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. Performance in relation to this target improved significantly during 2010/11, being achieved 90% of the time compared with 67% in 2009/10.

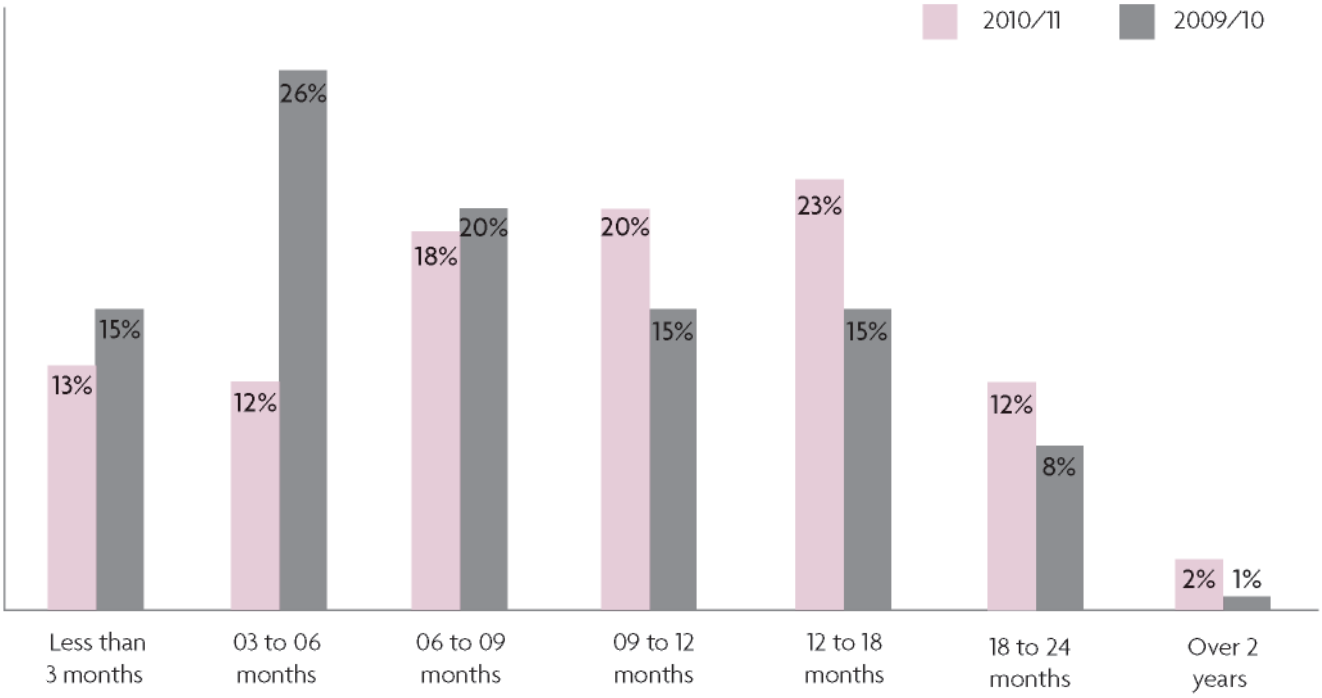
The second target we set ourselves is to conclude cases within 12 months from the point that a decision is made to take up a complaint (that is, to commence investigation of a complaint). The fact that we have been successful in closing so many 'older' cases during 2010/11 has ironically had an adverse effect on the outcome against this target. This was achieved in respect of 63% of cases in 2010/11 compared to 76% in 2009/10. However, we will now be well placed for a much improved position for 2011/12 – indeed, we have set ourselves the testing target of 100% of cases being closed within 12 months for the forthcoming year.

A more detailed breakdown of these decision times is set out in the charts below.

Decision times for informing complainants if complaint will be taken up



Decision times for concluding investigations of public body complaint cases



Complaints Advice Team

The Complaints Advice Team (CAT) became operational in January 2010 and has now matured into an effective service. The CAT deals with our frontline responses to the public 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, when we do receive formal complaints, the CAT is also charged with looking for effective, swift and innovative ways to resolve the 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.

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

- A complainant said that the Council was incorrectly asking him for payment of Residential Home care costs for his late wife, for a specific period. The complainant believed that the Independent Review Panel had access to the wrong admission date, which was reflected in the eligibility date. He had been unable to resolve this issue, and it had been ongoing for over two years. Following numerous telephone conversations, the Health Board confirmed to the complainant he would no longer have to pay for the period he was complaining about.
- A complainant called to tell us that she had had no hot water at her property for over a week and that she had contacted the Council on many occasions, but had had no response. She said that she was in desperate need of hot water as she had recently had a stroke, and was caring for her young grandson who suffers from cystic fibrosis. My staff contacted the Council to see if it had any record of the complainant's phone calls (which it did not). The Council was asked if it could take action regarding the lack of hot running water. The Council contacted the complainant to tell her that it would start work on installing a new boiler at her property the next day.
- A complainant was acting on behalf of her brother, who had learning disabilities. They complained that they were being repeatedly asked to send the same information to substantiate a claim for Housing/Council tax benefit, and their claim was due to be closed as it had been ongoing for some time. There appeared to be a difficulty in understanding the type of evidence which would be acceptable for the benefit claim. My staff spoke with its contact officer at the Council and raised the concern that the complainant was finding it difficult to understand the type of information needed. The Council arranged for the Team Leader of the Housing Benefit department to contact the complainant, with a view to offering a home visit if required. The complainant was happy with this outcome, and welcomed the chance to be assisted with providing the relevant documentation.
- A complainant reported dumped asbestos sheeting near his home to the Council. He said no one had been to pick it up. He expressed dissatisfaction that he had been passed from pillar to post and had spoken to virtually every public body and no one had sorted out the problem. My staff advised him of the Ombudsman's role in terms of making a complaint to the Council first but said that we would do what we could do help him. Having contacted the Council it was established that the report had not been passed to the appropriate person. The Council rang the complainant to find out exactly where the offending items were and went around the same day to pick them up.

- A complainant said that he had been given 12 dates by the Council to carry out works to his outhouse, which was damp and damaging the electrical goods he was storing in there, but that workmen had failed to turn up on each occasion. The complainant was very worried as winter was looming, and he felt that the situation would deteriorate and all his electrical goods would be irreparably damaged. The Manager of Council Repairs attended the complainant's house the same day my office spoke to them, and assessed the problem. As a result he agreed to install a vent for the complainant's tumble dryer (which was causing a damp issue) and to replace the damp ceiling with more substantial material. A date convenient for the complainant was arranged. The complainant was happy with this outcome.
- A complainant said that the council had incorrectly re-homed her dog after it had strayed as it did so before the expiration of their 7 clear days policy. The council re-homed the dog at 5pm on the last day, but the complainant stated that the 7 clear days did not expire until midnight of the 7th day. She had left a message on the kennel's voicemail at approx 9.30pm that night, and had the kennels adhered to their 7 clear days policy the kennel would have received her voicemail before re-homing the dog. The Council apologised for the error and said it would seek to amend the contract with the kennel to read "8 nights" so that the 7 clear days is always adhered to. It was not possible to get the dog back as the new family that it was now with refused. The complainant was dissatisfied with this response so came to us. My staff spoke with the Council and agreed that financial redress was not a viable option as it is difficult to put a value on the loss, but the Council agreed to offer the complainant the opportunity of attending the kennel to select a dog that needed re-homing. Should there not be a suitable dog on her first visit it would take the details and contact her should such a dog need to be re-homed.

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 277 new complaints, **down 21%** on 2009/10
- We referred 45 investigation reports to either a standards committee or the Adjudication Panel for Wales, **up 73%** on 2009/10.
- We closed 349 cases, **up 15%** on 2009/10
- We had no investigations older than 9 months old open at 31 March 2011

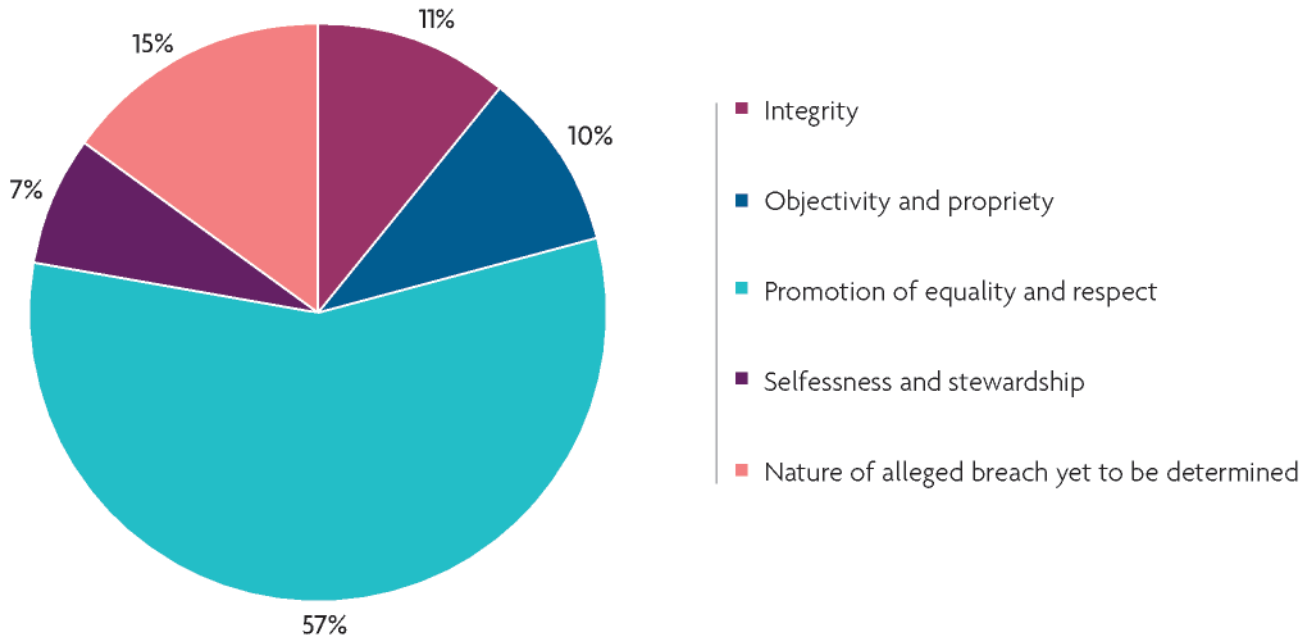
Complaints received

The table below gives a breakdown of the code of conduct complaints received by type of authority. Last year I reported my concern about a continuing increase in the number of complaints received, it has been pleasing therefore that this year there has been a decline of 21% in the number of complaints received. I address the reduction issue later in this section.

	2010/11	2009/10
Community Council	141	163
County/County Borough Council	135	183
National Park	1	3
Police Authority	-	3
Total	**277**	**352**

Nature of Code of Conduct complaints

As the chart below shows, the majority of complaints received during 2010/11 related to matters of 'equality and respect' (57% compared to 38% in 2009/10).



Summary of Code of Conduct complaint outcomes

Of the Code of Conduct cases considered in 2010/11 it was decided that the majority did not call for an investigation. 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 45 compared to 26 in 2009/10. This is partly a consequence of the higher number of cases closed during the year.

	2010/11	2009/10
Decision not to investigate complaint	194	214
Complaint withdrawn	16	16
Investigation discontinued	43	15
Investigation completed: No evidence of breach	13	6
Investigation completed: No action necessary	38	26
Investigation completed: Refer to Standards Committee	21	12
Investigation completed: Refer to Adjudication Panel	24	14
Total Outcomes – Code of Conduct complaints	**349**	**303**

(A detailed breakdown of the outcome of Code of Conduct complaints investigated, by local authority, during 2010/11 is set out at Annex C.).

With regard to the referrals heard by a Standards Committee or a tribunal of the Adjudication Panel during 2010/11, the outcomes were as follows:

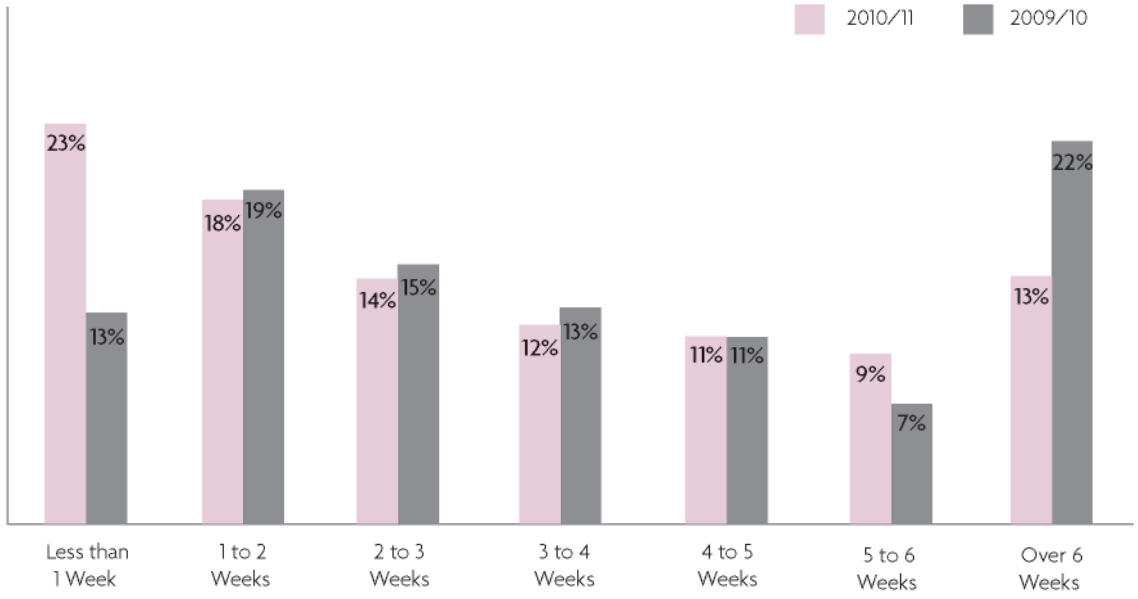
	No. of hearings	Outcome and Sanction (if any)
Adjudication Panel for Wales tribunals	11	Breach x 11 • 18 month suspension x 1 • 12 month suspension x 3 • 4 month suspension x 1 • 2 month suspension x 2 • 3 month partial suspension x 1 • 2 month partial suspension x 1 • No action x 2
Standards Committees	16	Breach x 14 • 6 month suspension x 1 • 3 month suspension x 1 • 2 month suspension x 1 • 1 month suspension x 1 • 28 day suspension x 1 • Censure & training x 1 • Censure x 5 • No action x 3 No evidence of breach x 1 No case to answer x 1

Decision times

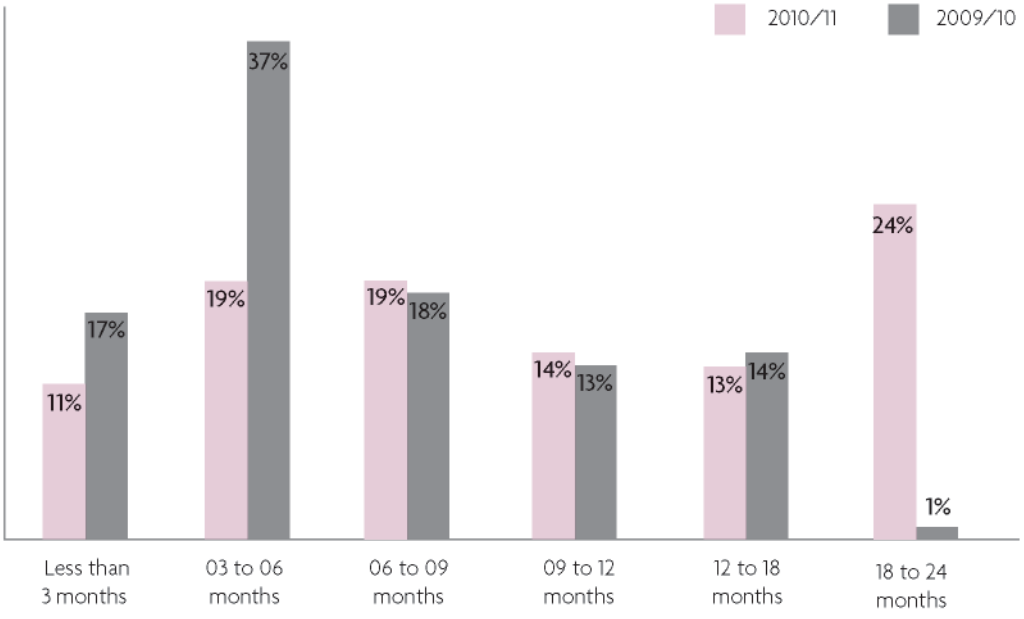
Below are the decision times for code of conduct complaints. The time targets set for code of conduct complaints are similar to those for complaints about public bodies, i.e.

- to tell complainants within 4 weeks whether we will take up their complaint.
- 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).

Decision times for informing complainants if Code of Conduct complaint will be taken up



Decision times for concluding Code of Conduct complaint cases



We have not been able to achieve the improvement in decision times for notifying complainants whether we will take up their complaint or not to the same extent as for complaints about public bodies. This to a large degree is a consequence of having to deal with these complaints in their initial stages in a different way. However, I am still pleased that we have been able to improve on last year's position.

I have been concerned over the past couple of years with the time it has been taking to deal with Code of Conduct investigations. I have previously explained that this is partly due to the consequences of members increasingly engaging legal representation. Nevertheless, I have also been aware that being the subject of a Code of Conduct complaint is a stressful experience for a councillor, often intensified by media speculation. Our process was therefore changed with a view to improving performance over this past year. Whilst the outcome of decision times for the past year in themselves are disappointing this is largely due to the impact of closing older cases during the year. It has also been impacted by the fact that 32 linked cases in respect of one particular authority was especially complex and took over 18 months to conclude. Having said this, I am very pleased that by 31 March 2011 we had reached the position where we had no Code of Conduct investigations open that were older than 9 months.

Code of Conduct for local authority members

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. A session was held on the guidance at the Annual Standards Conference, which was held in October. I believe that the publication of the guidance has made a positive contribution to the decline in the number of code of conduct complaints received by my office over the past year.

In addition, in issuing the guidance, I gave an undertaking that this would be a 'living' document and that, if the need arose, I would issue supplementary guidance. It has already become apparent that there are areas of the Code on which members and monitoring officers would welcome further direction and I intend issuing additional guidance on those areas in the forthcoming year.

I recognise that there has been concern about certain aspects of the Code and the use of complaints for political purposes. I would want to play a full part in any proposals for reform and believe that the experience of my office will offer a useful contribution to improving the framework in future.

5. The wider effect

Whilst my main role as an Ombudsman is to consider individual complaints, I am almost uniquely placed with the broad range of public bodies in my jurisdiction to be able to identify areas of wider learning for the public service in Wales.

Public interest reports

The ability to issue public interest reports, under section 16 of the PSOW Act, means that it is possible to achieve more than redress for the individual concerned. As well as making recommendations to ensure that the systemic problems identified by investigations are addressed by the body concerned to ensure that such problems do not happen again in the future, there are also wider benefits to publishing these reports. They 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. Further, public interest reports mean that there can be wider learning among similar public bodies, and prompt and encourage them to ensure that no similar systemic problems exist in their own organisation.

There were 13 public interest reports issued in 2010/11. 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, I have been conscious that although the issues may not be of public interest when considered in isolation, there may still be lessons that can be learnt if they form part of a pattern of similar outcomes. I therefore decided to introduce 'The Ombudsman's Casebook', a case digest, as a vehicle to enable any lessons that can be learned to emerge and the first issue was published in August 2010.

The Casebook is issued quarterly and has a wide circulation list, including bodies in jurisdiction, Assembly Members, voluntary organisations, etc. As well as containing summaries of all investigations closed, both those under Section 16 and Section 21 of the Public Services Ombudsman Wales Act, there is a 'Lessons Learnt' section which provides a commentary on issues I have identified as being of concern as a result of my investigations. Three digests had been published by the end of 2010/11; topics addressed were:

- failures to follow National Institute of Clinical Excellence (NICE) and Welsh Assembly Government guidelines
- pain management in A & E
- NHS continuing care funding eligibility
- NHS transport arrangements and transfer of patients
- urgent referral of suspected cancer
- anti-social behaviour
- recovering debts
- communication with service users
- record keeping.

Perhaps unsurprisingly, as health complaints make up a quarter of all complaints that I receive, it is this subject area which has provided the greatest learning opportunities.

I have been particularly heartened by the positive response to the Casebook. Whilst I consider the key audience to be bodies in jurisdiction so that they can learn from each other, there has been very positive feedback from regulators and voluntary organisations who have also found it a useful learning tool for their own purposes.

Annual letters

Another new initiative during the year was that I issued Annual Letters to bodies in jurisdiction in respect of their individual performance for 2009/10. This was limited to county/county borough councils and health boards, as it is only against these bodies that I receive the necessary volume of complaints to enable meaningful comparisons on an all Wales basis and to identify any trends. The Annual Letters were issued as a 'pilot' exercise, however, having taken account of the feedback received from the bodies concerned it is my intention this forthcoming year to publish the Annual Letters in respect of 2010/11 on my website.

Complaints Wales signposting service

I reported last year that since our three year Strategic Plan was developed a proposal was accepted that my office will provide a complaints signposting service for Wales. Originally an initiative of the Welsh Assembly Government it became clear, following an options appraisal and feasibility study that it undertook and discussions that I had with officials, that my office was well placed to deliver the service being sought. It would be a relatively small step to extend and enhance the service provided by the Complaints Advice Team. This would obviously offer key economies compared with setting up a service from scratch.

As I also reported last year, the development of the new service was contingent on securing the necessary additional public finance required to establish the new service. Given that I have to remain independent from government bodies, it would not be appropriate for me to act as an agent for the Welsh Assembly Government in this regard. It was, therefore, agreed that I would deliver this service in my own right, subject to the funding necessary to provide it being approved by the National Assembly for Wales. I, therefore, sought funding directly from the National Assembly as part of the normal budget round. That funding was approved in my budget submission for 2010/11. However, in respect of the budget round for 2011/12, there was a period of uncertainty surrounding the level of funding that my office would receive (I address this in more detail at page 30 of this report). As a result of this uncertainty, I decided to put the launch of the signposting project on hold until I was certain that the financial resources required to enable me to provide this service were available to me. Whilst this has now been resolved, I have not been able to introduce this service as early as I originally intended. However, a small scale pilot service began operating at the end of March and I now expect to be able to fully launch the Complaints Wales service in the early part of the forthcoming operational year.

The aim is that it should not only advise people on which public service provider they should complain to, but that it should also capture the crux of their complaint and (with the complainant's consent) send the details on to the relevant public body on their behalf. This can be done either by phoning the advice line or in due course via the website. However, it is not intended that the signposting service be a portal for all public service complaints. The service is primarily for people who need help to identify to whom they should be making their complaint and how best to do so. (Complainants who know who they should complain to, and how, should continue to complain directly to the relevant service provider.). In sending on the details of the grievance to the relevant public body, I will then look to it to accept this as a complaint made by complainants themselves and not to ask them to complete another form. In this way, those who have a grievance should have smooth access to the public body's complaints process.

Model complaints policy and guidance for public service providers

I reported last year that the Welsh Assembly Government was considering developing a common complaints handling process for public service providers in Wales and that I was asked to Chair a working group to put forward proposals for a model policy. The group, which was made up of people in a position to represent and consult with the various public service sectors in Wales, concluded its work in October 2010 and as its Chair I submitted advice to the First Minister. I was pleased that that advice received a positive response as announced by the First Minister at a Plenary Session of the National Assembly for Wales in November 2010 and I look forward to working with the Welsh Government during 2011 in relation to implementation.

6. Governance and Accountability

The Ombudsman

The Public Services Ombudsman (Wales) Act 2005 establishes the office of the Ombudsman as a 'corporation sole'. I am of course accountable to the National Assembly for Wales, both through the mechanism of this annual report, and because I am the Accounting Officer for the public funds with which the National Assembly entrusts me to undertake my functions.

Audit arrangements

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 current Chair of the Committee is Mr Laurie Pavelin, CBE, FCA. In addition, Professor Margaret Griffiths is an independent Member, who has wide legal expertise as it impacts on Wales. I am also a member of the Committee in my capacity as the Accounting Officer.

The Audit Committee considers matters such as budget estimates, annual accounts, external and internal audit reports, and risk management issues. It also considers matters including the Strategic and Operational Plans. The Committee met four times during 2010/11 and I am pleased that no substantive matters of concern were raised during the year.

RSM Tenon acted as my internal auditors and their programme of work is guided and overseen by the Audit Committee. With that company's contract coming to an end at 31 March 2011, a tender/interview process was held at the end of 2010 upon which the Committee advised. The successful company on this occasion was Deloitte, who were appointed for a three year term with the option by mutual agreement of a two year extension.

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.

Accountability

It is clear that the current arrangements for the accountability of my office to the National Assembly are flawed. I would value greater access to a Committee of the Assembly to allow discussion of the work of my office and the lessons learned, as well as to account for the results secured from the resources used. I will look to discuss these matters with the new Assembly in the coming year.

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, in view of our new ways of working, we decided that we should adopt a new approach to our satisfaction surveys. Where previously the research company Opinion Research Service (ORS) had provided a quantitative survey from the start to finish of our complaints process, we now conduct ourselves a satisfaction survey of all those complainants who contact our Complaints Advice Team. ORS provide 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 responses received in respect of the first six months were very positive. Service users were asked whether they agreed or disagreed with the statements below (the outcomes are shown in the second column):

	% of respondents answering either 'strongly agree' or 'agree'
It was easy to find out how to contact the Ombudsman's office	91%
The service I have received so far has been helpful and sensitive	93%
The person that dealt with the query knew enough to be able to answer my questions	91%
I was given a clear explanation of what would happen next to my concern	90%
The service provided what I expected of it	86%

The annual research report to be provided by ORS will not be available until June 2011.

Information technology – Case handling administration system

It had become evident that our existing case handling system would no longer be fit for purpose with the increase in caseload expected and also in order to meet the requirements of the new signposting system. In any event, the system we used was becoming obsolete and there were concerns about future support. Over the past year therefore, with our IT providers, we worked on developing an upgraded system. This was completed at the end of March. The system has also been developed so that it integrates with a new telephony system we have introduced and also our new websites.

External communication

Websites

It is clear from our research activities that the website is a key mechanism by which service users find out about my service. In addition, we needed to develop a website for the new Complaints Wales service. Therefore, during the year, and following a tender exercise, we appointed a company to both upgrade our existing website and also develop a new website for the Complaints Wales service. It is intended to launch the new sites early in 2011/12. The Complaints Wales website is being developed so that visitors to the site can identify the organisation they want to complain to and then, if they so wish complete an online form which will then be sent on directly to that organisation.

Complaints Wales Branding

The complaints signposting service has already been addressed in this report. It is important that the service should have its own separate identity from the Ombudsman's principal activities. Work took place during the year, therefore, on developing a brand for the service. The new logo (pictured left) will feature on the website, stationery and other public facing aspects of the service.

Outreach

With our communication resources having to be channelled towards the above developments, other outreach activities had to be curtailed during the year. Nevertheless, we have continued to take up opportunities to speak at conferences and seminars – for example, Community Health Councils, Public Law Project Conference Wales, Careers Wales and Community Housing Cymru. We have also continued to meet on a one to one basis with a range of organisations including representative bodies such as the Welsh Local Government Association, One Voice Wales and the Nursing & Midwifery Council, and voluntary organisations such as Hafal and Shelter Cymru,

In addition, we had a stand at the National Eisteddfod for Wales in Blaenau Gwent. This gave us an opportunity to explain our role to members of the public who called in to see us and also to engage with representatives of voluntary organisations who were present on the Eisteddfod field.

The outreach work of the office was extensively enhanced by media coverage of my investigation reports, which draws my service to the attention of members of the public who may wish to complain about public services in Wales. It has also provided an opportunity for me to be able to give a higher profile to the lessons that can be learned by public service providers from failings identified during my investigations. I have been particularly pleased with the level of television and radio coverage (both English and Welsh language) received during 2010/11.

Financial resources

In November 2010, I submitted my budget estimate for 2011/12 to the Finance Committee of the National Assembly for Wales. My original submission showed no increase on the budget for 2010/11 (based on full year costs). Using the latest Treasury figures, this represented a real terms reduction of 2.9% This submission was the subject of considerable discussion and correspondence with the Finance Committee who did not consider this to be a sufficient reduction. Consequently, I put forward a revised submission in January 2011, showing a reduction of 3% in cash terms in my core budget in response to the comments of the Finance Committee. This equates to a 5.7% reduction in real terms compared to 2010/11. In doing so, I made clear to the Committee that I have reservations as to whether it will prove possible to deliver my statutory obligations and to meet new pressures at this level, while acknowledging that other budget holders in the public service face similar issues. The principal savings will be on salaries, as many of my other costs are fixed.

Human resources

I would not be able to fulfil my function as Ombudsman if it was not for my staff. As has been evidenced in this report, I am fortunate in having a committed and expert workforce, but it is vital that provision is made to enable continual development. A review of our staff appraisal and training has been undertaken and proposals have been made to revise current arrangements. I expect this to be finalised in the early part of 2011/12. The staff appraisal and training processes are closely linked to our business objectives.

There is a service level agreement in place with the Wales Audit Office, who provide me with advice on human resources matters.

However, as I report above, the office will be facing a real terms reduction of 5.7% in the public funding it receives in 2011/12. This will present particular challenges in the year ahead in relation to the human resources of my office. To live within this budget, I will have to reduce my staffing establishment and also undertake a management restructure. The following posts will be cut: one Director (from two currently), two Senior Investigators, and two Casework Support Officers. By cutting these five posts from the establishment, the staffing of my office will be reduced by 8.5% (full time equivalents).

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 2011 is shown at the end of this section.

Children's and Older People's Commissioners – Memorandum of Understanding

We have continued to build our links with the Children's and Older People's Commissioners for Wales. I am particularly pleased that we were able to agree on and, in September 2010, sign a tripartite Memorandum of Understanding in relation to co-operation, joint working and the exchange of information. The Memorandum does not affect the existing statutory functions of our respective offices or the exercise of those functions.

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 Annual Meeting and conference took place in Cardiff in May 2010; the first time for it to be hosted in Wales. I was particularly honoured to be appointed as Chair of the Association during the occasion. I was also extremely pleased that Lord Dafydd Elis-Thomas, Presiding Officer of the National Assembly for Wales, and Dame Gillian Morgan, Permanent Secretary at the Welsh Assembly Government were able to address the delegates. As well as assisting with the arrangements for the conference, on the afternoon prior to the Annual Meeting, we as a PSOW office ran workshops for BIOA colleagues and were very pleased with the response. Indeed, demand was greater than anticipated but our contingency arrangements meant that we could accommodate everyone. Sessions were held on: Administrative Law; Redress and Managing Complainants' Expectations. Feedback for both the BIOA events and the workshops was pleasingly very positive.

I also greatly value the opportunity to participate in the UK and Ireland Public Sector Ombudsmen meetings.

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.

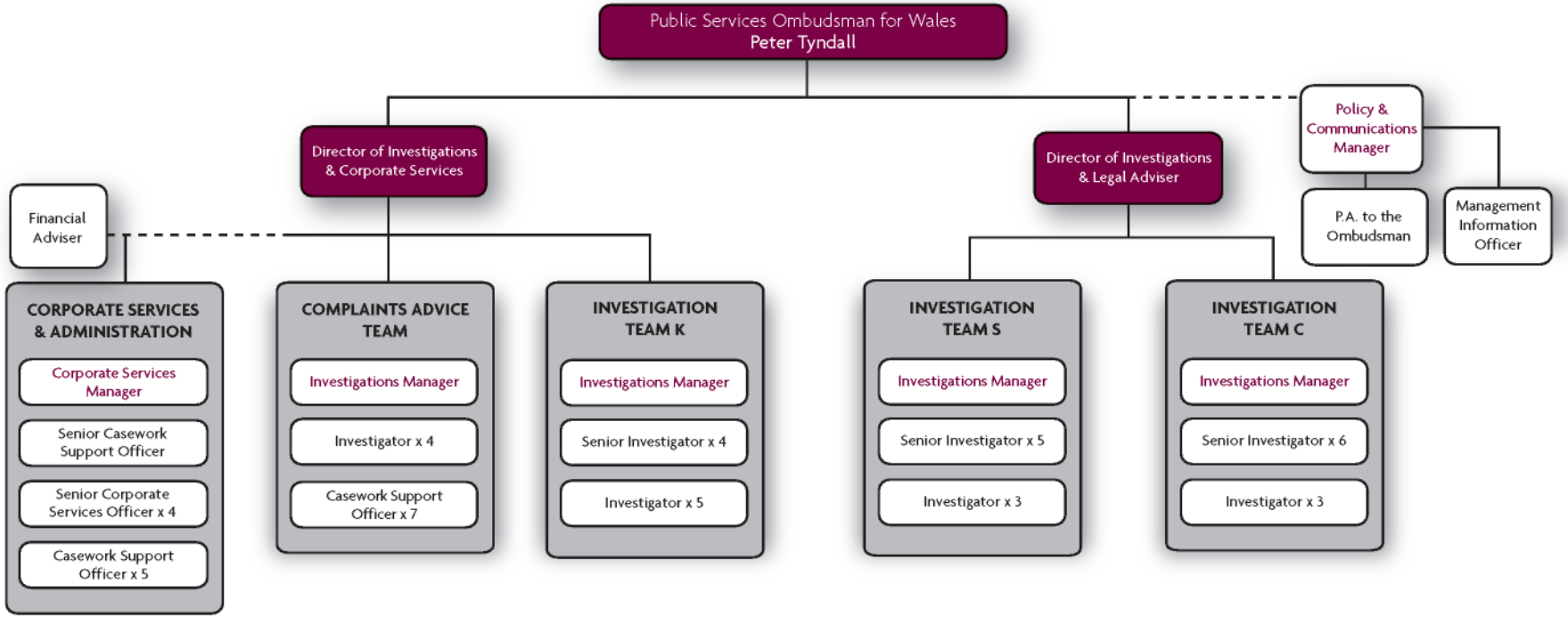
The table below reports on the number of complaints received during 2010/11 and their outcomes, together with a comparison of the position in 2009/10.

Details of the 'complaints about us' received	2010/11	2009/10
Not upheld	21	8
Referred to Investigation Manager/Investigator (case related/ appeal)	4	10
Upheld in whole or in part	3	5
Still open at 31 March	5	0
Total received	**33**	**23**

Details of the three cases upheld in whole or in part during 2010/11 are as follows:

Subject of complaint about us	Outcome	Action taken
Complaint concerning lack of regular updates during investigation.	Partially upheld.	Letter of apology sent.
Complaint that email requesting extension to investigation deadline had been overlooked	Partially upheld.	Letter of apology sent
Complaint regarding media release.	Upheld	Letter sent explaining circumstances of embargo and apology given.

Organisational Chart (position as at 31 March 2011)



Annex A

Public Body Complaints
Public Interest Reports: Case Summaries

Health

Healthcare Inspectorate Wales and Welsh Assembly Government
Case reference 200901222 & 201000062 – Report issued March 2011

Mr & Mrs A's teenage daughter was diagnosed with a terminal illness and was cared for at a children's hospice. The family's wish was to spend as much time together as possible and for Mr & Mrs A to manage many aspects of their daughter's care. Relations between Mr & Mrs A and hospice staff became strained. The hospice was concerned that its access to Mr & Mrs A's daughter and to her room was limited and they asked Healthcare Inspectorate Wales (HIW) for advice regarding possible breaches of relevant regulations. HIW sent in an inspector and an expert reviewer who listened to what the hospice had to say, and gave a view. The hospice subsequently met with Mr & Mrs A and said that staff must be allowed full access to their daughter and accept input from the care team otherwise she would be discharged.

Mr & Mrs A complained to HIW about this, about other concerns regarding care at the hospice, and subsequently also about HIW's involvement in the situation. HIW asked its expert reviewer to investigate the complaints. It later transpired that HIW did not have authority to conduct a complaints investigation, although it could look at matters involving the Regulations. The Welsh Assembly Government's complaints unit subsequently became involved.

I do not have jurisdiction for the hospice and was unable to investigate Mr & Mrs A's concerns about the hospice's actions. I investigated complaints against HIW and the Welsh Assembly Government. (A linked, and minor, complaint against the Care & Social Services Inspectorate for Wales was investigated and was not upheld.)

I found that HIW representatives had heard only the hospice's account of events and failed to seek the views of Mr & Mrs A and their daughter, particularly regarding her right (subject to limitations) to give or withhold consent for examinations. I found that HIW had focussed on the interests of hospice staff rather than the child and her family. However, I concluded that HIW had not mis-advised the hospice or threatened it with breaching the Regulations. I criticised the appointment of HIW's expert reviewer as complaints investigator as she was not sufficiently independent, having been involved in advising the hospice. I also criticised HIW's muddled handling of Mr & Mrs A's complaints, and considered that the Welsh Assembly Government's complaints unit could have intervened when it became apparent that Mr & Mrs A were unhappy with HIW's handling of the complaint.

I made a range of recommendations to HIW and the Welsh Assembly Government all of which they agreed to implement. I commented on my lack of jurisdiction for the hospice, and that there was no other independent body able to investigate Mr & Mrs A's concerns about the hospice. This is profoundly unsatisfactory. I asked the Welsh Assembly Government to consider what action it could take to bring the hospice into my jurisdiction.

North Wales NHS Trust (now Betsi Cadwaladr University Health Board) Case reference 200900780 – Report issued February 2011

Mrs R made a number of complaints to me regarding the care of her husband at Glan Clwyd hospital in 2008. Mr R sadly died at the hospital on 29 December 2008. He had been ill since October 2008, and had been diagnosed with cancer on 10 December.

I upheld several of Mrs R's complaints. The key findings were as follows:

- that Mr R's consent for a biopsy was not informed consent as there was insufficient time for him to properly consider the procedure and ask questions;
- that Mr R was discharged on Christmas Eve without proper planning and before full clinical investigations had been undertaken;
- that when Mr R was re-admitted to the hospital on 28 December he was not seen by a senior clinician;
- that it was not reasonable for the ward sister to have insisted on weighing Mr R, who was by this time very ill;
- that clinical staff failed to recognise the seriousness of Mr R's condition or his deterioration.

The last point in particular caused me concern as this issue had arisen in previous investigations about care at Glan Clwyd hospital. I made a range of recommendations regarding patient consent, review by a consultant, end of life care, and discharge planning; and asked the Health Board to instigate its own investigation into Mr R's care from October 2008 onwards, and into the care of other patients whose complaints about Glan Clwyd hospital had been the subject of investigation by me. I recommended that the Health Board apologise to Mrs R for the failings identified during the investigation, pay her £250 for her time and trouble in pursuing the complaint, and reimburse her £50 charged for copies of Mr R's clinical records. The Health Board agreed to implement all of my recommendations.

Cardiff and Vale NHS Trust (now Cardiff and Vale University Health Board) Case reference 200802452 - Report issued January 2011

Mrs F complained about the standard of care afforded to her late son, X, by the Trust's Mental Health Services, before his death in October 2008 (when he took his own life). During his care period he had expressed a suicidal intent, taken an overdose, and had harmed himself whilst on holiday with Mrs F. She complained that X had been discharged from the Trust's Crisis Home Treatment Team's ("Crisis Team") care too soon, after 2 ½ weeks, when he went away with her. Further, when he attended a Trust hospital immediately from the airport on his return, seeking admission, he was denied. Mrs F complained that the Trust had failed to admit him to hospital throughout because of a shortage of beds.

Following advice from my clinical advisers, the complaint was mostly upheld. The investigation found that:

- the threshold for admission to a hospital bed (such admission being governed solely by the Crisis Team) appeared to be at a high level given there was no clear policy guidance or definition as to what constituted a "severe case" warranting admission;
- the high bar coloured the way in which X was dealt with, given he had not previously been known to the Trust's services. This was particularly evident immediately following his return from the trip with Mrs F, when he had self harmed;
- there was no clear guidance in place as to what should happen when patients recently discharged from the Crisis Team's care presented themselves at a hospital front desk, out of hours, requesting admission.

I did not uphold the complaint that any shortage of beds had influenced the decision not to admit X, as I was satisfied that a bed could have been sourced elsewhere if required. Rather, the reason was the high threshold for admission. I could not either find that X would not have ended his life when he did had he actually been admitted as hospital admission is not the solution for many patients. As a matter of good practice, I also found that the Trust should have undertaken a more thorough and objective investigation into X's death (a Root Cause Analysis – RCA), as opposed to the Multi Disciplinary meeting involving those who had treated him that took place. This would have resulted in identifying the lack of guidance about presenting out of hours, which the Trust agreed was required.

I recommended that the Trust apologise to Mrs F for the failures identified and offer her redress for the need to pursue the investigation (which might have been avoided had a RCA been undertaken). Further recommendations included a review of the threshold and criteria for admission to hospital, a written procedure for a patient's 'out of hours' presentation at hospital, and a reminder to senior staff within Mental Health Services about the need for a RCA investigation particularly where the death of a patient occurs.

GP in Abertawe Bro Morgannwg University Health Board area
Case reference 200901952 – Report issued December 2010

Mr K complained about treatment that his mother, Mrs K, received from her GP. Mr K said that the GP failed to diagnose or refer Mrs K appropriately when she presented symptoms to him. Mrs K was later diagnosed with renal cancer in hospital and sadly died. Mr K maintained that an urgent referral from the GP may have prevented her death.

I found that the GP should have referred Mrs K urgently after one particular consultation. During that visit Mrs K told the GP that she had passed blood in her urine and had pain in her abdomen. I found that the GP should have referred Mrs K to a specialist for suspected cancer. Clinical guidelines indicate that blood in the urine should lead to such a referral under what is known as "the two week rule". This means that a patient is seen by a relevant specialist within the two weeks. By not doing so in this case, the GP made a significant error. I concluded that Mrs K would have had a much better chance of survival if the GP had made the referral. Therefore, whilst noting that the GP had acknowledged the

matter, learned from it and apologised on various occasions, I upheld the complaint. I recommended that the GP apologise again and pay Mr K £3000 in recognition of the additional suffering he has endured due to the uncertainty about what outcome might have resulted from an appropriate and prompt referral.

Hywel Dda Health Board
Case reference 200901551 – Report issued September 2010

Mr JL complained that his brother had been transferred between hospitals by taxi, without a nurse escort or oxygen and accompanied only by his wife. He complained that, due to the confusion caused by his illness and its treatment, Mr ML did not have the mental capacity to understand what the transfer entailed or to make an informed decision to agree to the transfer. He also complained that there was inadequate preparation or communication with Mr ML's family prior to the transfer taking place.

I found that Mr ML had not been properly assessed to establish whether or not he had the mental capacity to consent to the transfer and there was no record of any formal consent having been obtained from Mr ML. I also found that the medical records showed little evidence of any discussion with Mr ML or his family about the proposed transfer. I found that there was no evidence to suggest that Mr ML had been properly assessed as being safe to travel unescorted. I found that the record keeping in general was substandard, with documentation poorly completed by staff, if at all, on many occasions.

I also found that a Ward Sister had falsified an entry in Mr ML's medical records, more than a year after he had died. I concluded that this was done in order to conceal the fact that the Ward Sister had failed to notify Mr ML's wife of his proposed transfer the following day and also to make it look as though Mr ML's wife had agreed to accompany him on the taxi transfer. I found that the falsification of the entry in the medical records was a deliberate attempt to mislead and obstruct my investigation.

I recommended that the Health Board should formally apologise to Mr JL and his family for the failings identified in this report. I also recommended that the Health Board should carry out an audit of the standard of record keeping at Bronglais General Hospital and review its procedures for discharging and transferring patients.

I also recommended that the Health Board should review the care provided to Mr ML and thereafter consider whether further staff training was necessary. I recommended that the Health Board should remind all staff of the importance of ensuring that evidence provided to my office during the course of an investigation is comprehensive and accurate. Finally, I referred a copy of the report to the Nursing and Midwifery Council in order that it could consider the conduct of the Ward Sister responsible for tampering with Mr ML's medical records.

Cardiff Local Health Board and Cardiff and Vale NHS Trust (now Cardiff and Vale University Local Health Board) Case reference 200802231 & 200802232 – Report issued August 2010

Mrs P complained that her adult son (Mr P), who had advanced Huntington's disease, had been in hospital unnecessarily for two years having been admitted for what she had understood would be a two week period of rehabilitation. Mrs P was concerned about the proposed plans for her son's discharge and future care as although he had previously expressed a wish to stay at home, the NHS services with responsibility for Mr P felt that it was not possible to care for him safely at home with the resources then available. Mrs P also disputed an assertion that Mr P needed 24 hour care and complained that the reasons she was given for Mr P being admitted to hospital were not accurate.

Turning to Mrs P's complaints about the length of time her son was in hospital and the arrangements for his future care, I found that there had been a failure to carry out adequate assessments, a failure to take into account all the relevant facts of the case, and that there had been excessive delay. Had comprehensive assessments been done within a reasonable time, and had all the relevant facts been adequately considered, then it was possible that Mr P would have been able to return home sooner than he did. I upheld this part of the complaint. I recommended that Cardiff & Vale University Local Health Board (as it now is) should apologise to Mrs P for the failings identified in the report and pay her £1,500 in recognition of the time and trouble she was put to in pursuing the complaint and the inconvenience she was put to in visiting Mr P every day to feed him (as the hospital staff were unable to do this). I also recommended that the Health Board remind staff of the need to carry out full assessments, take specialist advice where necessary, and consider, where appropriate, assisting carers to access relevant training. The Health Board agreed to implement the recommendations.

I found that there had been some confusion about the reasons for Mr P's admission, but the evidence did not suggest that Mrs P was misled. I therefore did not uphold this part of the complaint.

Education

Gwynedd Council and Welsh Assembly Government Case reference 200801217 & 200900897 – Report issued May 2010

Mr K complained about the way in which his claims for Assembly Learning Grant and Disabled Student Allowances ("DSAs) had been processed by the Council and Student Loans Company Ltd ("SLC") (which was carrying out student finance functions on behalf of the Welsh Assembly Government). He complained that following his withdrawal from a PGCE course on health grounds, and despite repaying a proportion of the grant, the Council made a number of unnecessary reassessments of his grant entitlements resulting in 7 notifications from SLC demanding the repayment of all or varying parts of the grant.

He complained further that SLC unreasonably withheld payment of his DSA claims (which he was entitled to in respect of the PhD course he was pursuing at another university) pending repayment of the grant which it claimed had been overpaid. Mr K complained finally that neither the Council nor the SLC responded to his complaints adequately, and that each blamed the other.

I upheld the complaint. The investigation showed that there were failures by the Council and SLC respectively to make correct reassessments and to issue correct overpayment recovery letters to Mr K following his withdrawal from the PGCE course. The Council and SLC also failed to communicate with each other promptly and effectively to resolve the difficulties on Mr K's account when these became manifestly apparent from his correspondence with both organisations. Instead, they blamed each other and withheld payments to which Mr K was entitled. There were also failures to respond to Mr K's correspondence and his subsequent complaints in a proper manner. In particular SLC's statement to Mr K that it had no record of his emails (including hard copies forwarded subsequently) was dissembling and disingenuous given that as a result of other action being taken by SLC at the time, the email facility was not available.

I recommended that the Council and SLC apologise to Mr K and pay him a total of £700 to compensate him for the injustice he sustained. The Council, SLC and the Welsh Assembly Government indicated that measures are being taken to address the difficulties which occurred in Mr K's case including the "system" problems. Nevertheless, I recommended that all three bodies should provide me with an update on these measures, including arrangements for identifying problems at a much earlier stage, the improvement of communication between the SLC and local authorities in Wales, and improvements in dealing with correspondence and complaints from students.

Planning and Building Control

Isle of Anglesey County Council
Case reference 200901501 – Report issued March 2011

Mr W complained that after he sought planning permission for the use of his site for commercial storage purposes, the Council wrongly granted planning permission for raising the height of a boundary wall on a neighbouring site which detrimentally affected visibility at the access to the trading estate on which both sites were located. He complained further that the Council failed to secure a reduction in the height of the wall. As a consequence, he was unable to implement his own permission which had been granted subject to a condition preventing the use of the site until the height of the wall was reduced. He also suffered financial losses and claimed that his costs of developing the site following the eventual reduction in the height of wall were significantly greater than they would have been had he been able to develop the site following the grant of an unrestricted planning permission in a timely manner.

His complaint was upheld. The plans of the proposed development on the neighbouring site showed some information regarding the proposal to raise the height of the wall, but the Council failed to recognise this and/or failed to obtain further information from the applicant. The raised height of the boundary wall adjacent to the access to the trading estate was detrimental to highway safety.

The evidence showed that the Council had failed subsequently to address the issue and to respond satisfactorily to correspondence from Mr W's agent. Eventually, and after Mr W complained to me, the Council secured the reduction in the height of the wall some 2 years later.

The Council was recommended to reimburse Mr W's company its financial losses (assessed at £30,626) by means of an initial payment of £20,000, and the balance within 12 months of the commencement of trading on the site, as adjusted if necessary in the light of any significant new information emerging regarding the precise extent of the assessed losses. The Council was further recommended to pay his Company a sum equivalent to the difference between the estimated costs of developing the site had planning permission been granted in a timely manner in 2008 and the sums actually paid when he does so, and a contribution of £1500 towards Mr W's costs in pursuing the complaint. Finally, the Council was recommended to draw my report to the attention of the Commissioners (appointed by the Welsh Assembly Government in March 2011 to take over the Council's executive powers).

Social Services

Powys County Council
Case reference 200801373 – Report issued July 2010

Mr and Mrs A provide full time care for their disabled granddaughter, Miss B. Respite care is provided by Miss B's aunt. Mr and Mrs A complained about the manner in which the Council had dealt with their application for direct payments (that is, providing funding to service users to enable them to purchase services rather than providing services directly) for Miss B. They said that direct payments would enable them to provide care to Miss B in a more flexible manner. Instead Miss B receives care funding through the Independent Living Fund, which requires Miss B to attend day services. These are at set times every day and Mr and Mrs A stated that they and Miss B often find it difficult for her to attend. Mr and Mrs A also complained that the Council should have offered direct payments to them, as Miss B's guardians, whilst she was still a child. Had this happened, they said, Miss B would have been able to continue to receive direct payments as an adult.

I found that, at the present time in Wales, the legislation only entitles those who are able to consent to having direct payments to be eligible to receive them. Miss B is unable to express any consent and therefore there was no maladministration on behalf of the Council in determining that she was not eligible. Whilst the Council should have offered direct payments to Mr and Mrs A when Miss B was a child, I concluded that this had not caused injustice to Mr and Mrs A. This was because, at that time, respite care was being funded by Children's Services and it would not have changed the position for Mr and Mrs A once Miss B became an adult. There was no right to continue to receive Direct Payments. However, I found that the Council had failed to consider Miss B's case appropriately. It was clear that it was in her best interests to continue to be cared for by her family and that the Council should have looked at all options to facilitate this. One such option was funding her care via a trust. Whilst this was suggested in 2007, it was never followed up at the time and has only recently been considered again. I could see no reason why a trust could not have been set up in 2007. The Council's failure to offer this

option to Mr and Mrs A amounted to maladministration, which had resulted in Mr and Mrs A pursuing matters with the Council through solicitors for several years. I recommended that the Council apologise to Mr and Mrs A and make a payment to them of £2000 in recognition of their having to pursue their complaint and the uncertainty caused to them for several years about the funding of Miss B's care.

Merthyr Tydfil County Borough Council
Case reference 200800881 – Report issued July 2010

Mr and Mrs A complained about the manner in which Social Services had dealt with the placement of Mrs A's grandchildren with them. They had understood that they would get ongoing financial support but this was never forthcoming. Mrs A also complained about the lack of supervision and support provided by Social Services. They felt that they had been left very much to deal with matters on their own. They had subsequently applied for a residence order for the children to remain with them and felt that the Council should pay them a residence order allowance towards the children's upkeep.

The Council stated that the children had gone to live with Mr and Mrs A as part of a private family arrangement and therefore financial support for the children was provided by the Welfare Benefits system in the form of tax credits and child benefit. It had given a one-off payment of £4000 to the family towards their housing costs to reflect their circumstances.

I upheld the complaint. I did not accept that it was a private arrangement within the family. There were serious concerns of abuse at the time, which the Council failed to investigate in line with statutory Child Protection Procedures. This was serious maladministration. However, I acknowledged that the Council had taken action to safeguard the children's welfare by placing them with Mr and Mrs A. As the Council had not followed Child Protection Procedures, there was a lack of clarity about the children's status. The Council's record keeping was also poor. I was of the view that the evidence indicated that the children were placed with Mr and Mrs A by the Council and, therefore, were 'looked after' children and should have been treated as such.

I recommended that the Council pay Mr and Mrs A the difference between what they received in benefits for the children and the fostering allowances that would have been paid by the Council for the period before the residence order was obtained, in addition to a further payment for the other identified shortcomings.

I partly upheld Mr and Mrs A's complaint about the Council's decision not to pay them an ongoing residence order allowance, in recognition of the fact that the decision should have been taken from the standpoint of the children being 'looked after'. However, I accepted that Residence Order Allowances were discretionary payments and the Council had taken account of the family's individual financial circumstances in reaching its decision not to make ongoing payments.

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	Investigation not merited	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	2	4	5				1			**12**
Bridgend	2	9	13	2	3		6	4	1	**40**
Caerphilly	7	28	13	1	2		10	2	3	**66**
Cardiff	16	33	23	2	4		11	3	1	**93**
Carmarthenshire	12	26	21	1	1		3	2	1	**67**
Conwy	4	9	12		1		2	2	1	**31**
Cyngor Sir Ceredigion	1	19	12		2		2	3		**39**
Denbighshire	2	12	11		4		3		2	**34**
Flintshire	1	11	13	2	5		5		2	**39**
Gwynedd		18	12	1	2	1	3	2		**39**
Isle of Anglesey	5	12	10	1	4	1	3	3		**39**
Merthyr Tydfil	2	9	4	1		1	1		1	**19**
Monmouthshire	3	6	7				5	1		**22**
Neath Port Talbot	4	20	18	1	2			3		**48**
Newport	4	18	3		5		1	1	1	**33**
Pembrokeshire	2	19	17		3		1	2		**44**
Powys	4	19	18		5	1	14	4	2	**67**
Rhondda Cynon Taf	5	21	24	2	3		4	2	3	**64**
The City and County of Swansea	4	15	20	2	2		4	1		**48**
The Vale of Glamorgan	3	12	14	9	4		8	2	1	**53**
Torfaen	2	11	8		3			2	2	**28**
Wrexham	2	18	4	1	6		7	2	2	**42**
TOTAL	**87**	**349**	**282**	**26**	**61**	**4**	**94**	**41**	**23**	**967**

OTHER LOCAL AUTHORITY

Other Local Authority	Out of Jurisdiction	Premature	Investigation not merited	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		3	1				1	2	1	**8**
Pembrokeshire Coast		4	3							**7**
Snowdonia		1						1		**2**
TOTAL		**8**	**4**				**1**	**3**	**1**	**17**
Police Authorities										
Dyfed-Powys	1		1							**2**
TOTAL	**1**		**1**							**2**
Schools Appeals/ Admissions Panels										
Admissions Appeal Panel- Cwrt Rawlin Primary School			1							**1**
Admissions Appeal Panel-Christ the King Catholic Primary School	1									**1**
Admissions Appeal Panel - Bassaleg School		1								**1**
Admissions Appeal Panel - St Josephs High School			1							**1**
Admissions Appeal Panel - Cardiff High School				1						**1**
Admissions Appeals Panel- Pembroke Road Primary School				1						**1**
TOTAL	**1**	**1**	**2**	**2**						**6**
Drainage Boards										
Powysland Internal Drainage Board				1						**1**
TOTAL				**1**						**1**
OVERALL TOTAL 'OTHER LOCAL AUTHORITY'	**2**	**9**	**7**	**3**			**1**	**3**	**1**	**26**

COMMUNITY/TOWN COUNCILS

Community/Town Council	Out of Jurisdiction	Premature	Investigation not merited	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
Amroth			2							**2**
Beaumaris		2	2							**4**
Clydach	1									**1**
Ganllwyd			1							**1**
Gorslas			1							**1**
Gwauncaegurwen	1									**1**
Llangennech		1								**1**
Llansannan		1								**1**
Llansteffan		1								**1**
Llanwrtyd Wells		1								**1**
Monmouth		1								**1**
Newtown & Llanllwchaiarn		1								**1**
Onllwyn			1							**1**
Pembroke Dock	1									**1**
Pontypridd		1								**1**
Prestatyn		3	1							**4**
Ruabon					1					**1**
St Arvans			1							**1**
St Clears		1								**1**
Tenby			1							**1**
Trelech a`r Betws	1									**1**
Tywyn		1								**1**
Ystradgynlais			1							**1**
TOTAL	**4**	**14**	**11**		**1**					**30**

REGISTERED SOCIAL LANDLORDS

Registered Social Landlord (Housing Association)	Out of Jurisdiction	Premature	Investigation not merited	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	1									**1**
Bron Afon Community	1	6	4					1	1	**13**
Cadwyn		1			1					**2**
Cardiff Community		1					1			**2**
Cartrefi Conwy									1	**1**
Cartrefi Cymunedol Gwynedd		3	2							**5**
Charter Housing Association (1973) Ltd		6	1		1			1	1	**10**
Clwyd Alyn		5	3							**8**
Coastal Housing Group Ltd			1							**1**
Cymdeithas Tai Cantref	1				1					**2**
Cymdeithas Tai Clwyd Cyf							1			**1**
Cymdeithas Tai Eryri		1	1							**2**
Cynon Taf Community Housing (2007) Ltd	1									**1**
Family Housing Association (Wales) Ltd			2							**2**
Grwp Gwalia Cyf Ltd		1			2		1			**4**
Hafod		2			2			1		**5**
Linc-Cymru		1	1	1					2	**5**
Melin Homes Ltd	1		1							**2**
Merthyr Tydfil		1	1							**2**
Merthyr Valleys Homes		1	4							**5**
Monmouthshire		2								**2**

REGISTERED SOCIAL LANDLORDS (continued)

Registered Social Landlord (Housing Association)	Out of Jurisdiction	Premature	Investigation not merited	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		3	1							**4**
Newydd		1			1					**2**
Newydd Housing Association (1974) Ltd		1	1							**2**
North Wales Housing								3		**3**
Pembrokeshire		1					1			**2**
RCT Homes Ltd		5	1							**6**
Tai Calon		1	1							**2**
Tai Ceredigion Cyf			1		1				1	**3**
United Welsh		4	2					1		**7**
Valleys to Coast		1	2							**3**
Wales and West		6	1					2		**9**
TOTAL	**5**	**54**	**31**	**1**	**9**		**4**	**9**	**6**	**119**

NHS TRUSTS AND LOCAL HEALTH BOARDS

The NHS in Wales was subject to major re-organisation in 2009. Details below therefore reflect complaints received in respect of the Local Health Boards and NHS Trusts which existed prior to 1 October 2009. Complaints received by my office on or after 1 October 2009 have been recorded against the new organisations, although some of these complaints relate to predecessor health bodies for which these bodies took over responsibilities and liabilities.

Local Health Boards (pre October 2009)	Out of Jurisdiction	Premature	Investigation not merited	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**
Caerphilly					2					**2**
Cardiff				1		1	1			**3**
Carmarthenshire							4	1		**5**
Gwynedd							1			**1**
Merthyr Tydfil								1		**1**
Neath Port Talbot					1					**1**
Powys					2		2			**4**
Rhondda Cynon Taff					10					**10**
Swansea					1					**1**
Torfaen					2			1		**3**
TOTAL				**1**	**19**	**1**	**8**	**3**		**32**

NHS TRUSTS

NHS Trusts (pre October 2009)	Out of Jurisdiction	Premature	Investigation not merited	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							4			**4**
Cardiff & Vale						2	12	2		**16**
Cwm Taf							5	3		**8**
Gwent Healthcare							7			**7**
Hywel Dda							4	3		**7**
North Glamorgan							1			**1**
North Wales						1	5	3		**9**
North West Wales							1	1		**2**
Welsh Ambulance Services							1			**1**
TOTAL						**3**	**40**	**12**		**55**

LOCAL HEALTH BOARDS/NHS TRUSTS (1 October 2009 and thereafter)

Health Boards/NHS Trusts (1 October 2009 and thereafter)	Out of Jurisdiction	Premature	Investigation not merited	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	1	19	11		4		4	3	3	**45**
Aneurin Bevan Health Board	3	16	8		3		7	1	3	**41**
Betsi Cadwaladr University Health Board	3	19	11	1	2		9	3	4	**52**
Cardiff and Vale University LHB	2	15	13	2	3		7	3		**45**
Cwm Taf Local Health Board	2	6	7		2		7	1	1	**26**
Hywel Dda Local Health Board	1	5	5	1	3	1	1			**17**
Powys Teaching LHB	1	2	6	1	4		2	3		**19**
Public Health Wales NHS Trust		1								**1**
Velindre NHS Trust							1	1		**2**
Welsh Ambulance Services NHS Trust		1	4		1					**6**
TOTAL	**13**	**84**	**65**	**5**	**22**	**1**	**38**	**15**	**11**	**254**

TOTAL ALL LHB/NHS TRUST COMPLAINTS	**13**	**84**	**65**	**6**	**41**	**5**	**86**	**30**	**11**	**341**

OTHER HEALTH BODIES

Other Health Bodies	Out of Jurisdiction	Premature	Investigation not merited	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
Aneurin Bevan Community Health Council			1							**1**
Brecknock & Radnor Community Health Council			1							**1**
Board of Community Health Councils		1	1							**2**
Dentist		3	3						1	**7**
GPs	2	11	13		1	1	9	12	1	**50**
TOTAL	**2**	**15**	**19**		**1**	**1**	**9**	**12**	**2**	**61**

INDEPENDENT HEALTH PROVIDER

Independent Health Provider	Out of Jurisdiction	Premature	Investigation not merited	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
The London Women's Clinic Swansea								1		**1**
TOTAL								**1**		**1**

WELSH ASSEMBLY GOVERNMENT & WELSH ASSEMBLY GOVERNMENT SPONSORED BODIES

Welsh Assembly Government & AGSPBs	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	S16 Report - Not Upheld	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Assembly Sponsored Public Body											
Countryside Council for Wales					1						**1**
Environment Agency	3	1	3	1	1			1	3		**13**
Higher Education Funding Council for Wales (HEFCW)			1								**1**
Sports Council for Wales		1	1								**2**
The Forestry Commissioners (for matters relating to Wales)	1										**1**
Welsh Assembly Government											
CAFCASS Cymru	2	1	4	1						4	**12**
CSSIW							1	1			**2**
Health Commission Wales								1	1		**2**
Healthcare Inspectorate Wales		3			2	1					**6**
Independent Review Secretariat			3						2		**5**
Planning Inspectorate		2								1	**3**
Welsh Assembly Government	5	9	9		3	2		1	1		**30**
Welsh Health Specialised Services Committee		1									**1**
TOTAL	**11**	**18**	**21**	**2**	**7**	**3**	**1**	**4**	**7**	**5**	**79**

OTHER BODIES

Other	Out of Jurisdiction	Premature	Investigation not merited	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
Body not in jurisdiction	6									**6**
ESTYN		1	1							**2**
East Wales Valuation Tribunal			1							**1**
Valuation Tribunal Service for Wales			1							**1**
Total	**6**	**1**	**3**							**10**

Annex C

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

COUNTY/COUNTY BOROUGH COUNCILS

County/County Borough Council	Decision Not to Investigate	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Blaenau Gwent	1			2				**3**
Bridgend	2			1				**3**
Caerphilly	4			1	2			**7**
Cardiff	11			1	1		1	**14**
Carmarthenshire	4			1				**5**
Conwy	1							**1**
Ceredigion	3			1			1	**5**
Denbighshire	3						2	**5**
Flintshire	8		2			2	1	**13**
Gwynedd	4	1			1			**6**
Isle of Anglesey	9					2		**11**
Merthyr Tydfil	6		1	1	1	5		**14**
Monmouthshire	5		1	4	2	2		**14**
Neath Port Talbot							1	**1**
Newport	1							**1**
Pembrokeshire	2		1				1	**4**
Powys				2				**2**
Rhondda Cynon Taf	6			1				**7**
The City and County of Swansea	8	34	1				2	**45**
The Vale of Glamorgan	1							**1**
Torfaen	10	1		1	2	7	1	**22**
Wrexham	3							**3**
TOTAL	**92**	**36**	**6**	**16**	**9**	**18**	**10**	**187**

COMMUNITY/TOWN COUNCILS

Community/Town Council	Decision Not to investigate	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Bishopston	1							**1**
Blaenhonddan	1							**1**
Borth	1				2			**3**
Brymbo	1							**1**
Bryngwran							1	**1**
Buckley	1							**1**
Caldicot Town Council					1			**1**
Cardigan	4							**4**
Clydach	2							**2**
Coedffranc	1	3		1			1	**6**
Conwy				1				**1**
Coychurch Higher				1				**1**
Ffestiniog		2						**2**
Flint			1					**1**
Ganllwyd	2							**2**
Glynneath	1							**1**
Gorseinon	5	1	1					**7**
Gwersyllt	1							**1**
Haverfordwest	2							**2**
Hawarden	1							**1**
Llanddowror	3							**3**
Llandeilo	2							**2**
Llanfairfechan				1			1	**2**
Llanfechain	5							**5**
Llanfihangel Ystrad	1							**1**
Llangennech	1							**1**
Llangynwyd Lower					1			**1**
Llanidloes				2				**2**

COMMUNITY/TOWN COUNCILS (continued)

Community/Town Council	Decision Not to investigate	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Llantrisant	1							**1**
Llay	8			1				**9**
Manorbier	2				2			**4**
Mold	2							**2**
Old St. Mellons	2			1				**3**
Onllwyn					3			**3**
Pembroke Dock			1	4				**5**
Pencaer			1					**1**
Penrice					1			**1**
Pontarddulais	11							**11**
Ponthir	1							**1**
Pontypool	1							**1**
Portskewett	1							**1**
Prestatyn	15		3	3			2	**23**
Pyle							1	**1**
Resolven	1							**1**
Rhyl	7							**7**
Saltney	2					4		**6**
Shotton	1							**1**
St Brides Major		1			2			**3**
Tenby	1			5				**6**
Tonyrefail	1							**1**
Trelawnyd & Gwaenysgor				1				**1**
Tudweiliog						1		**1**
Tywyn Community	1							**1**
Tywyn Town	3							**3**
Willington & Worthenbury	1							**1**
TOTAL	**98**	**7**	**7**	**21**	**12**	**5**	**6**	**156**

NATIONAL PARK AUTHORITIES

National Park Authority	Decision Not to investigate	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 Coast	1			1				**2**
TOTAL	**3**			**1**				**4**

POLICE AUTHORITIES

Police Authority	Decision Not to investigate	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
North Wales	1					1		**2**
TOTAL	**1**					**1**		**2**

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 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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