Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

PUTTING THINGS RIGHT: DRIVING IMPROVEMENT

ANNUAL **REPORT** 2012/13



Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

The Annual Report 2012/13

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

1	Introduction	**4**
2	Role of the Public Services Ombudsman for Wales	**8**
3	Complaints of maladministration and service failure	**10**
4	Code of Conduct complaints	**16**
5	Improving Public Service Delivery	**22**
6	Governance	**24**
7	Other Activities	**27**
8	Equality	**33**
Annex A	Public Body Complaints: Public Interest Reports Case Summaries	**38**
Annex B	Public Body Complaints: Statistical Breakdown of Outcomes by Public Body	**46**
Annex C	Code of Conduct Complaints: Statistical Breakdown of Outcomes by Local Authority	**57**
Annex D	Extract from Strategic Plan 2012/13 to 2014/15: Vision, Values, Purposes and Strategic Aims	**63**

1. Introduction

I am pleased to introduce this, my fifth, annual report since taking up my post as Ombudsman. Its key theme is 'Putting Things Right, Driving Improvement', which mirrors the theme of my new three year strategic plan, which we began implementing at the start of 2012/13. As Ombudsman, I see two principal 'reasons for being': that is to put things right for users of public services when I find things have gone wrong, and then to drive improvement in the delivery of those public services using the learning from the complaints I consider. I also take the opportunity to discuss below some wider issues which have emerged in relation to the role of the Public Services Ombudsman for Wales (PSOW) which we will wish to pursue in the forthcoming year.

Public service delivery by private sector organisations

In a public service landscape where the distinction in delivery between public and private sectors becomes increasingly blurred, it is important that people's access to redress is not inadvertently denied to them. I have therefore welcomed the Welsh Government's recognition of this in its provisions in the Social Services and Well-being (Wales) Bill and the proposals to extend the PSOW's jurisdiction so that I may consider complaints from those people who, for example, pay for their own social care in private care homes as well as those people who have their care paid for by the State.

I have over the past couple of years spoken widely, including internationally, on the issue of ensuring that people have access to redress in respect of public services delivered by private sector organisations. I have also written a number of articles on the subject. This is a matter which requires further attention in respect of the position in Wales. In England, for example, consideration is being given to bringing private healthcare into the Health Service Ombudsman's jurisdiction. I do not believe however that the taxpayer should bear the cost of redress arrangements for private sector complaints. One possibility would be to address this by a levy as operated by some private sector ombudsmen schemes, where all bodies in jurisdiction pay towards their running costs, often based on the size of the body concerned. The second option would be based on the number of complaints. This incorporates an element of the "polluter pays" principle, and is said to encourage bodies in jurisdiction to better address complaints internally to avoid the costs associated with complaints going to the Ombudsman. Some ombudsmen schemes incorporate an element of both funding arrangements. Schemes which rely heavily on a pay per complaint model can have great difficulties in workforce planning as income streams are not predictable, so I would be cautious in advocating this approach. I will in due course wish to pursue discussions with the National Assembly on these issues.

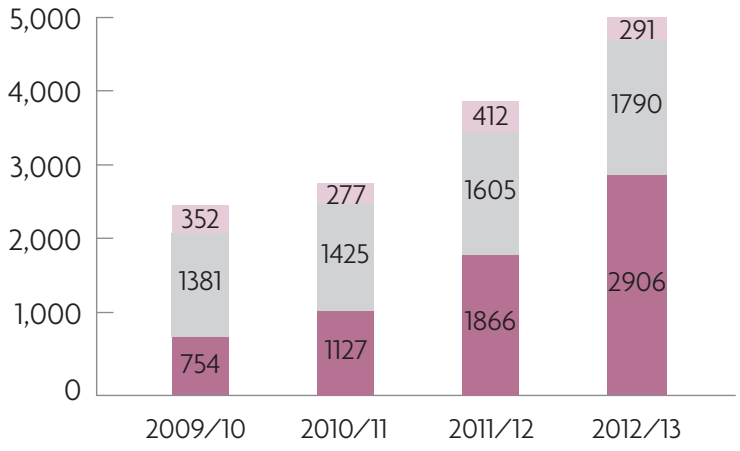
The Public Services Ombudsman (Wales) 2005 Act

At the time of its introduction the Public Services Ombudsman (Wales) Act 2005 (PSOW Act) was considered to be at the cutting edge of ombudsman legislation and is still one of the most highly regarded in the UK and internationally. However, experience over the seven years of the office's operation and changes in the external environment during that time has revealed areas of the legislation which could be strengthened, changed and developed. This includes the issue of private sector delivery referred to above, but also matters such as 'own initiative powers'. Virtually without exception, public services ombudsmen throughout Europe, and indeed, internationally, have the power to undertake investigations on their own initiative. The Ombudsman in the Republic of Ireland already has such a power and it is proposed that it should be introduced in Northern Ireland also. I have, therefore, begun discussions with the National Assembly for Wales concerning a review of the legislation with a view to its amendment or replacement. I have received a positive initial response to my proposals and I look forward to future discussions on this matter.

Three Year Strategic Plan

The past year saw the start of the implementation of the new three year Strategic Plan. Our revised vision, values, purposes and aims can be found at the end of this report. The plan builds on the previous three years, which had seen significant changes in the way we operate and innovations introduced. This included the introduction of the Complaints Advice Team, the frontline service of the office, which subsequently also became responsible for providing the Complaints Wales signposting service, and our new, innovative websites which supported these services. We also streamlined our investigation processes. This was particularly necessary in the climate of the financial constraints faced by the office, in line with all of the public sector, during this period whilst having to deal with an ever increasing caseload.

In taking stock of the past year against the three years of the previous Strategic Plan, it is worth commenting on that increase. Over this period, there has been a 100% increase in all contacts with the office from 2,487 in 2009/10 to 4,987 this past year. This is illustrated below. I will discuss the increase in the volume of work, and its impact, in more detail in following sections of this report.



Total Enquiries and Complaints received by year

- Enquiries
- Public Body Complaints
- Code of Conduct Complaints

The continuing rise in health complaints has to be an area of considerable concern. Since the office came into existence in 2006/07, complaints about health bodies have increased by 257%. I have attributed past rises to a number of factors, such as an increase in the awareness of my office, the likelihood that members of the public are more prepared to complain in general and changes within the NHS's own complaints process over the past couple of years. But this continued significant increase has to lead to the conclusion that there is greater dissatisfaction with health service delivery. It is also noticeable that all of the public interest reports that I have issued during 2012/13 relate to health matters (see Annex A). There has been much media attention on this area of the public service with more and more health professionals speaking out about their own concerns and frustrations from within the service. No-one underestimates the difficulties in providing a service in a climate of limited resources with greater calls on those resources. It is clear that people's expectations are raised with continual news of new breakthroughs in medical science, with what was previously untreatable becoming treatable – at a cost. However, from the complaints I see, there is a suggestion that the NHS in Wales needs also to go back to basics when the fundamental aspects of care such as providing proper nutrition, proper consent for surgical procedures and end of life care pathways are not in place.

Governance

During the course of the year I introduced a new Advisory Panel to strengthen governance and to be better able to demonstrate greater openness and transparency in the work of my office. I was fortunate in being able to form a diverse Panel of members bringing expertise and experience from a variety of relevant backgrounds. I discuss this further at Section 6 of this report. Although the Panel is still in its infancy, the wider perspective and experience that they bring to the work of my office is proving to be very helpful.

Last year I thanked Mr Laurie Pavelin for his excellent support as Chair of the Audit Committee over a period of six years. I take the opportunity in this report to record that I was delighted to be able to appoint Mr Ceri Stradling as his successor, and that he has already made an active and significant contribution.

In expressing thanks, I must of course recognise the work of my staff over the past year. With the growth in caseload and increase in other activities of the office I am grateful to them for their continued dedication and professionalism in the work delivered. In addition, it would be remiss of me if I did not give particular thanks to Mr Malcolm MacDonald, my Financial Adviser, as he retires. Mr MacDonald has been at the office of the Public Services Ombudsman for Wales since its inception. He has truly been a valuable member of staff and I wish him well for the future.

Finally, my Annual Report for 2011/12 was considered by a Committee of the National Assembly rather than during a Plenary Session. This was the first time for such an arrangement. I very much welcomed this development, and am grateful to the Presiding Officer, Rosemary Butler, for facilitating it. I was pleased to have the opportunity to be present to discuss the work of my office in person as opposed to having to watch the debate on my report from the sidelines. I understand that the members of the Communities, Equality and Local Government Committee also found it a positive development. I look forward to having a similar opportunity to discuss this report with the Committee during 2013.

Peter Tyndall
Ombudsman

2. The Role of the Public Services Ombudsman for Wales

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

Complaints about public bodies in Wales

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

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

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

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

The PSOW Act 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 were four such reports issued during 2012/13. However, I did have cause for concern over the past year when one of these four reports received media attention. The PSOW Act as it currently stands only allows me to direct the public body concerned not to give any publicity to the report, it does not extend to other parties involved in the complaint.

The PSOW Act 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. We have made steady progress in resolving complaints in this way and I am pleased that it has been possible to sustain the record level of settlements achieved last year (see page 13 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 2,906 enquiries, **up 56%** on 2011/12.
- We received 1,790 new complaints, **up 12%** on 2011/12.
- We achieved 177 quick fixes/voluntary settlements, **a similar level** to the 176 achieved in 2011/12.
- We issued 241 investigation reports, **up 35%** on 2011/12.
- We closed 1,725 cases, **up 11%** on 2011/12.
- We had 382 cases on hand at 31 March 2013, **down 16%** on 2011/12.
- We had 1 investigation more than 12 months old open at 31 March 2013.

Caseload – overall position

The number of complaints about public bodies that I receive continues to increase. As the figures in the table below indicate, the overall level of new complaints has increased by 12% compared to the position for 2011/12.

	Total Number of Complaints
Cases carried over from 2010/11 (includes Code of Conduct complaints)	295
New public body complaint cases 2011/12	1,605
Total complaints 2011/12	**1,900**
Cases carried over from 2011/12 (includes Code of Conduct complaints)	455
New public body complaint cases 2012/13	1,790
Total complaints 2012/13	**2,245**
Cases to be carried forward to 2013/14 (includes Code of Conduct Complaints)	**382**

In addition, the office dealt with 2,906 enquiries during 2012/13, compared with 1,866 the previous year.

I am particularly pleased that despite the increase in both enquiries and complaints to my office, the efforts of my staff has meant that the number of complaints in hand at the year end has been reduced from 455 to 382. There will, of course, always be a certain number of complaint cases open at any one time and I consider this level to be manageable. However, I am conscious that if the volume of complaints continues to rise in the future, this will be a challenging position to sustain.

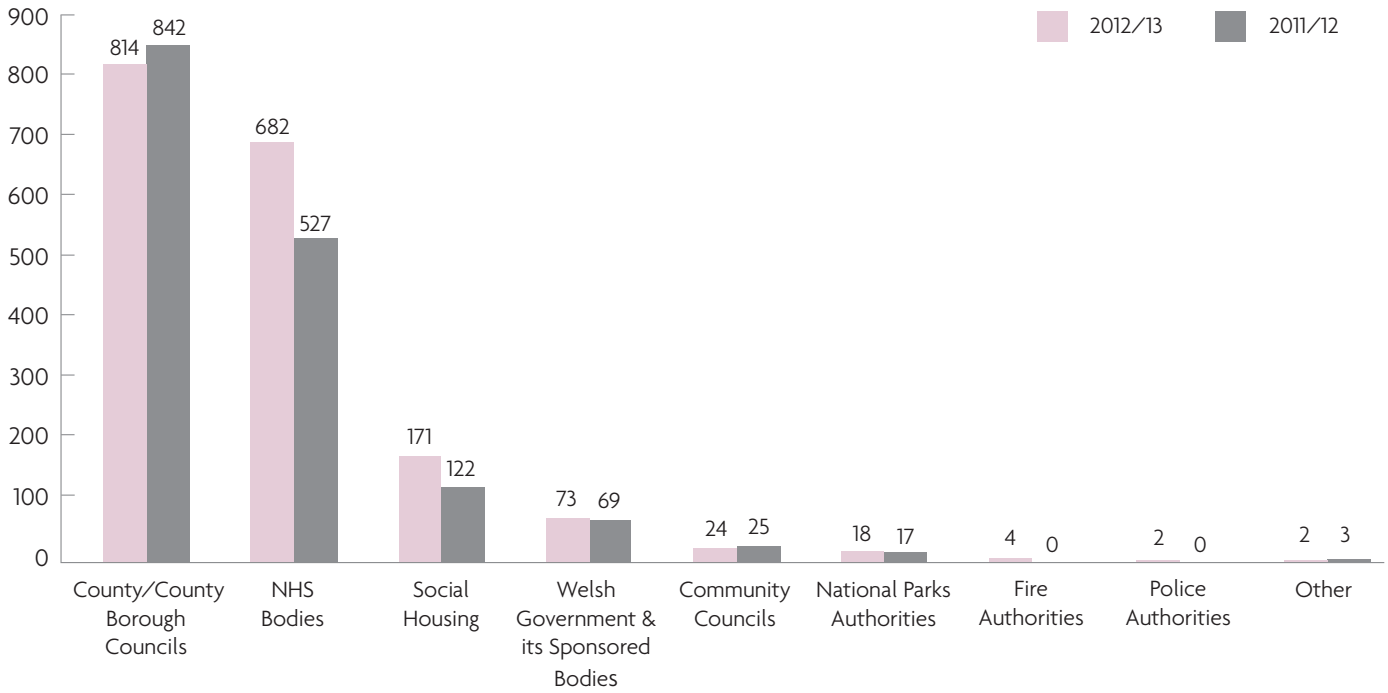
Sectoral breakdown of complaints

The chart below shows the trends in complaints received per sector. Complaints about county councils continue to be the most numerous, but it is pleasing to see for the first time since the inception of the office a decline in the number received.

County councils are direct providers of a wide range of services to the public and it is therefore not surprising that they should be the source for the greatest number of complaints.

However, I drew attention in my report last year to the exponential increase in complaints about NHS bodies. That sharp upward trend continues with 682 such complaints having been received in 2012/13 compared to 527 in 2011/12, which is a 30% increase.

Complaints by public body sector

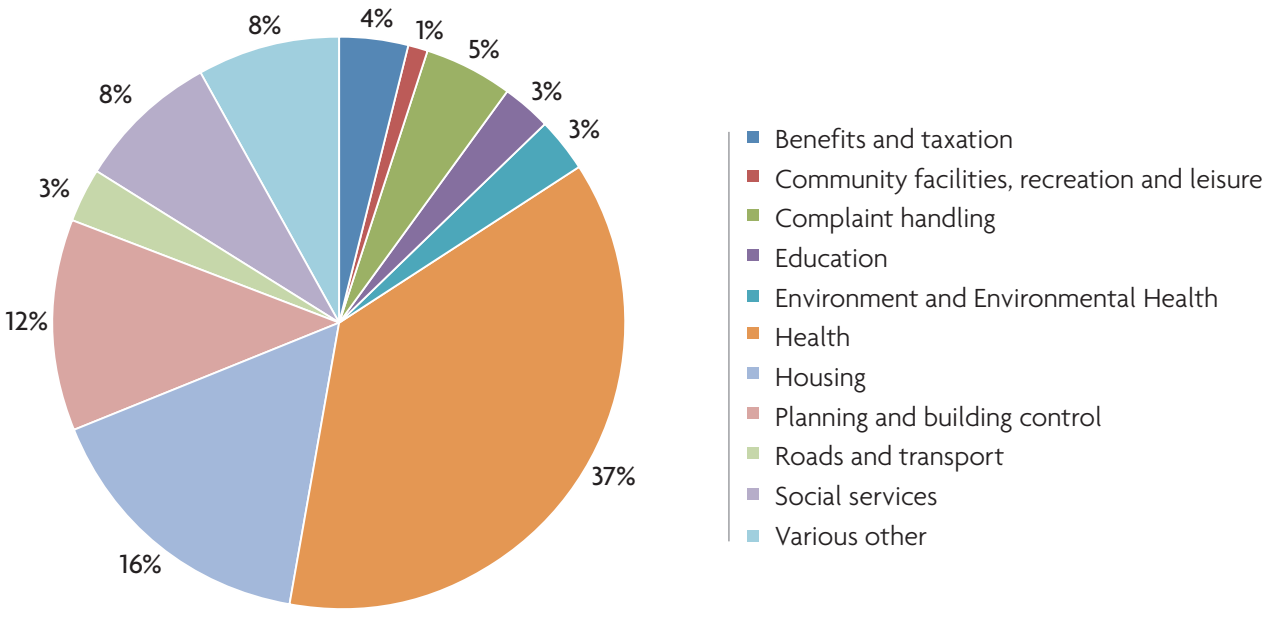


Complaints about public bodies by subject

The level of health complaints is confirmed when considering complaints by subject area. For the past five years, health complaints have been the most numerous types of complaint received. In the PSOW's first year of operation (2006) health complaints accounted for 16% of the caseload, however as can be seen below, it now accounts for 37%. Some of this increase can be attributed to the concentration of all independent reviews of health complaints into my office under the 'Putting Things Right' health redress arrangements. However, it must be recognised that the increase almost certainly reflects a greater dissatisfaction with the health service.

Following the pattern of previous years housing and planning are the next largest areas of complaint, although for the first time since the office came into existence, planning complaints are noticeably fewer in number compared to those about housing matters. It is likely that this change can be attributed to the current state of the economy.

Complaints by subject 2012/13



[Note: Complaints are categorised by the main subject area of a complaint. However, complaints can also comprise other areas of dissatisfaction - for example, a 'Health' complaint may also contain a grievance about 'Complaint Handling'.]

Outcomes of complaints considered

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

- were outside of my jurisdiction
- were premature (that is, the complainant had not first complained to the public service provider, giving them an opportunity to put matters right)
- did not provide any evidence of maladministration or service failure
- did not provide any evidence of hardship or injustice suffered by the complainant
- showed that little further would be achieved by pursuing the matter (for example, a public body may have already acknowledged providing a poor service and apologised)

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

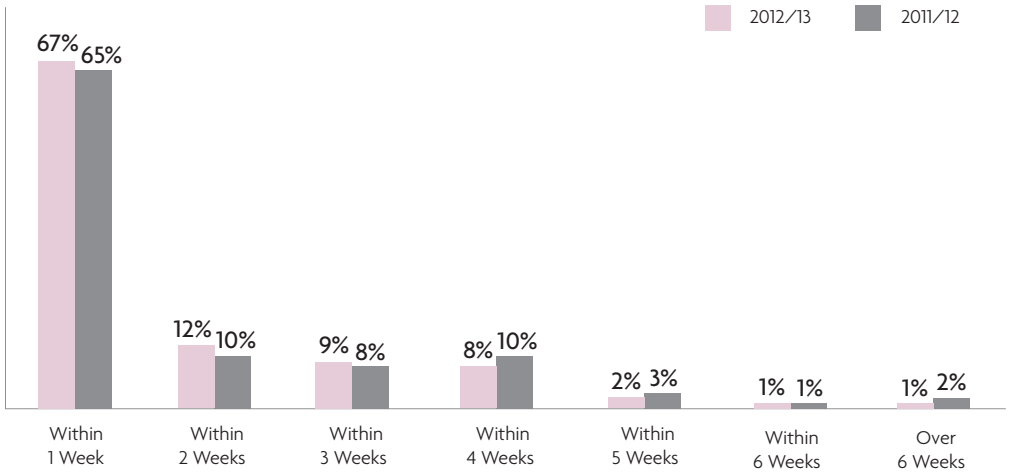
Complaint about a Public Body	**2012/13**	**2011/12**
Closed after initial consideration	1,260	1,168
Complaint withdrawn	26	14
Complaint settled voluntarily (includes "quick fix" of 150 cases)	177	176
Investigation discontinued	21	19
Investigation: complaint not upheld	68	60
Investigation: complaint upheld in whole or in part	163	106
Investigation: complaint upheld in whole or in part – public interest report	10	14
Total Outcomes – Complaints	**1,725**	**1,548**

Decision times

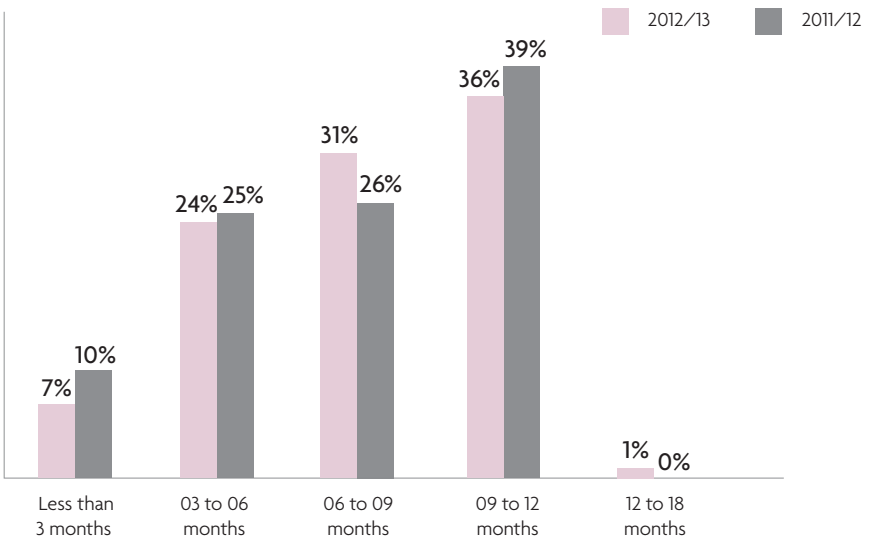
Overleaf are two charts which report on the decision time targets we set ourselves. We aim to tell complainants within four weeks whether we will take up their complaint from the date that sufficient information about the complaint is received. Performance in relation to this measure has continued to improve. For 2012/13 we raised the bar and set ourselves the more stretching target of achieving the four week deadline 90% of the time (compared to 85% in 2011/12). That 90% target was surpassed and we informed 96% of complainants within this timescale.

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). It is a slight disappointment that we did not quite manage to achieve a 100% success rate in this area, as the second chart shows. Four cases went beyond the 12 months investigation target. One of these was a health case which required advice from several clinical advisers throughout the process – despite the lengthy investigation the complainant nevertheless expressed her gratitude that the investigation had established the events surrounding her mother's death. Another two cases involved protracted discussions with the relevant councils concerning the findings of my reports and to arrive at agreement to implement my recommendations. Finally, in the fourth case there was a delay in issuing the draft report and unfortunately it was not possible to conclude the discussions with the Council on the recommendations within the timescale set. This case was closed just one day short of the 12 month target.

Decision times for informing complainants if complaint will be taken up



Decision times for concluding investigations of public body complaints



Complaints Advice Team

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

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

I am pleased that despite the increased level of enquiries received by my office that we have been able to provide a prompt service at the frontline. We set ourselves the target of answering our main line reception calls within 30 seconds in 95% of cases. It is an outstanding achievement that in 2012/13 we answered 100% of calls on our main line within this timescale.

However, beyond dealing with enquiries, the CAT is also charged with looking for effective, swift and innovative ways to resolve concerns when we do receive formal complaints. They look to see if there are means to address complainants' concerns, without the need to progress matters to detailed investigation. We clearly cannot control the number of complaints coming to the office suitable for this type of resolution. However, I am pleased that we were able to achieve 150 'quick fixes'. We have now begun to include summaries of the complaints we resolve via a 'quick fix' in the Ombudsman's Casebook (see page 22 for more details).

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 291 new complaints, **down 29%** on 2011/12.
- We referred 20 investigation reports to either a standards committee or the Adjudication Panel for Wales, **up 5%** on 2011/12.
- We closed 371 cases, **up 8%** on 2011/12.
- We had no investigations older than 9 months old open at 31 March 2013.

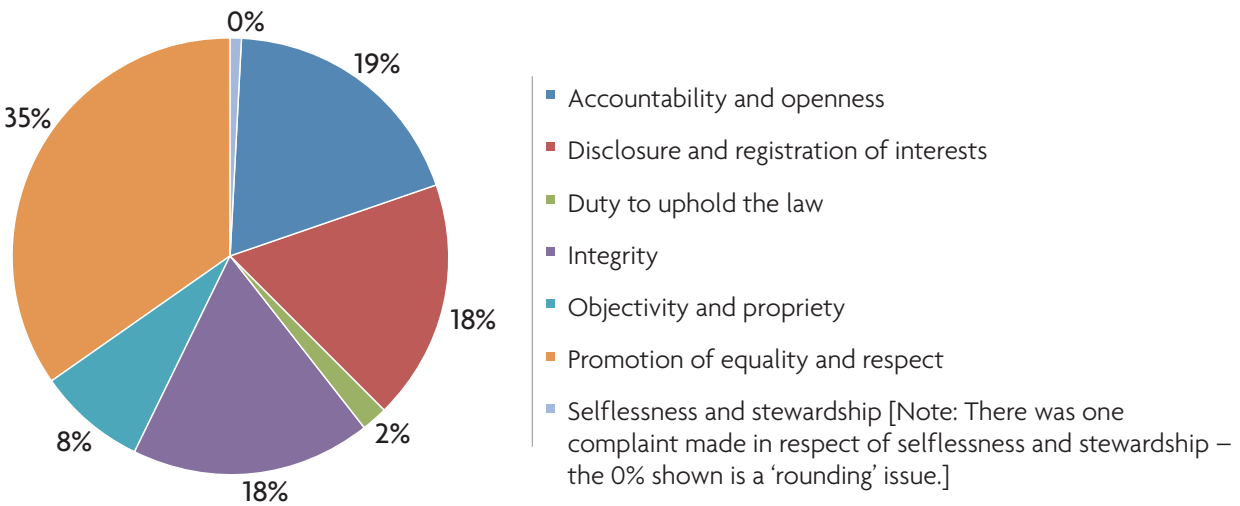
Complaints received

The table below gives a breakdown of the code of conduct complaints received by type of authority. I am pleased that the number of code of conduct complaints received by my office decreased by 29% over the past year. This is largely due to the fact that 2011/12 was an election year and that the Code of Conduct complaints system was inappropriately used as a tool for political mischief making. However, I believe that the reduction can also to a degree be attributed to the success of new local resolution arrangements recently introduced, which I address later in this section.

	2012/13	2011/12
Community Council	140	205
County/County Borough Council	150	178
National Park	0	28
Police Authority	1	1
Total	**291**	**412**

Nature of Code of Conduct complaints

As the chart below shows, the majority of complaints received during 2012/13 related to matters of 'equality and respect' (35% compared to 39% in 2011/12). The increase in the number of complaints relating to 'objectivity and propriety' seen during 2011/12 to 25% (from 10% in 2010/11) has during the past year returned to a lower level, comprising 8% of the Code of Conduct caseload.



Summary of Code of Conduct complaint outcomes

Of the Code of Conduct cases considered in 2012/13, the majority were closed under the category shown below as 'Closed after initial consideration'. This includes decisions such as:

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

The number of cases which I concluded should be referred to either an authority's standards committee or to the Adjudication Panel for Wales was 20 compared to 19 in 2011/12.

Complaint about a public body	2012/13	2011/12
Closed after initial consideration	283	280
Complaint withdrawn	12	0
Investigation discontinued	18	9
Investigation completed: No evidence of breach	23	7
Investigation completed: No action necessary	15	29
Investigation completed: Refer to Standards Committee	15	15
Investigation completed: Refer to Adjudication Panel	5	4
Total Outcomes – Code of Conduct complaints	**371**	**344**

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

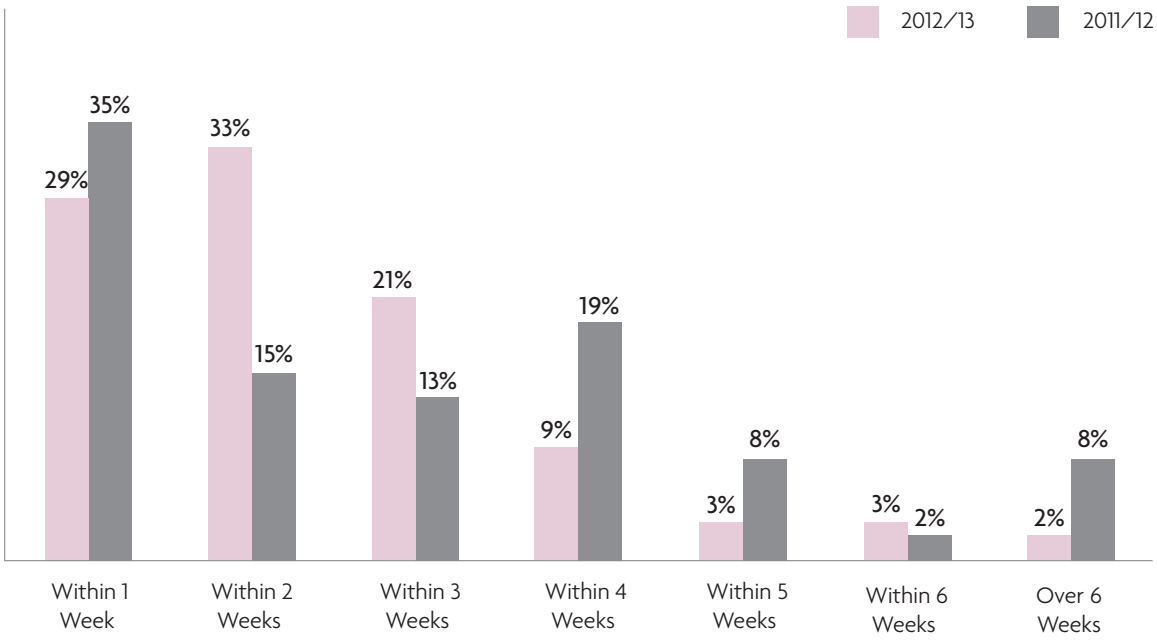
Decision times

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

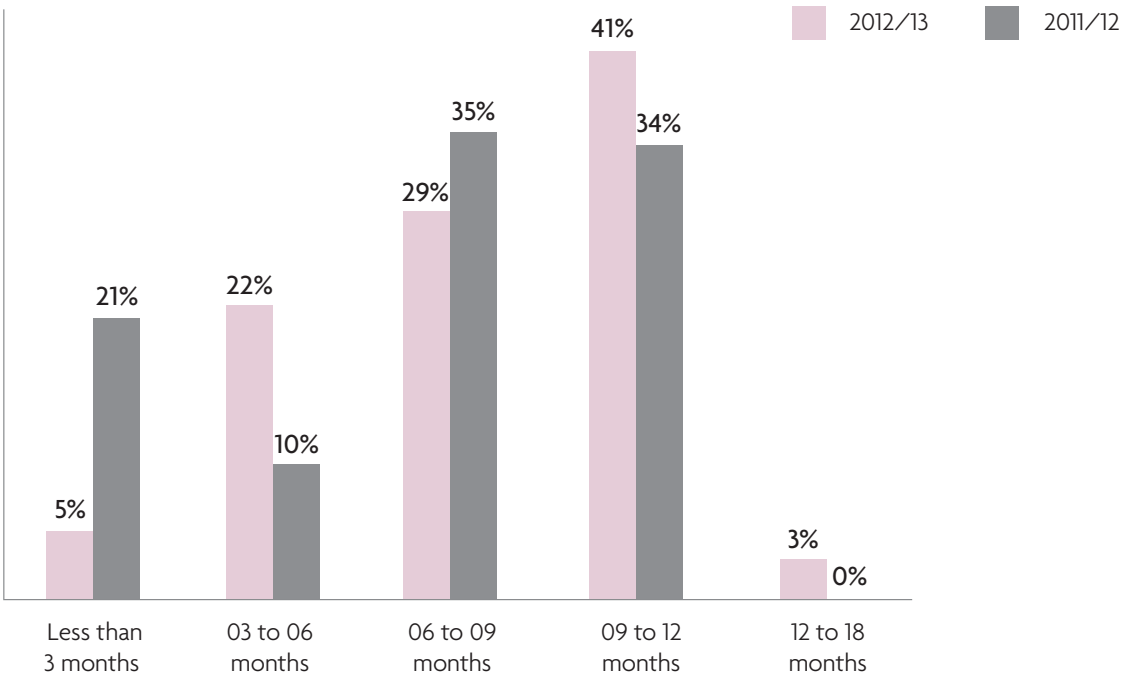
- to tell complainants within 4 weeks whether we will take up their complaint from the date that sufficient information about the complaint is received
- to conclude cases within 12 months from the point that a decision is made to take up a complaint (that is, to commence investigation of a complaint).

In respect of the first target, and similar to that for public body complaints, we set a more testing challenge for 2012/13, aiming to achieve this 90% of the time. We actually did so 92% of the time. This is particularly pleasing in view of the fact that we have to deal with Code of Conduct complaints in their initial stages in a different way from those in respect of public bodies and that the rate achieved in 2011/12 was 82%.

Decision times for informing complainants we will take up their complaint



Decision times for concluding Code of Conduct investigations



I have commented in previous Annual Reports about the steps we have taken to improve on the time that it takes us to complete Code of Conduct investigations and the fact that these are often affected by the consequences of members increasingly engaging legal representation. Whilst it is a little disappointing that we have not been able to sustain the investigation times achieved during 2011/12, we are nevertheless completing investigations in a far more timely manner than in the years previous to this (for example, in 2010/11 37% of code of conduct cases took over 12 months to complete). The 3% shown as taking over 12 months in 2011/12 actually equates to two cases. In the first case, a late request was made by the accused member for certain arrangements to be put in place in respect of his interview. This led to the target being missed by 12 days. In relation to the second, an internal review of a draft investigation report led to the provisional conclusion at draft report stage that the case should be referred to the Adjudication Panel for Wales rather than a Standards Committee. This necessitated some additional work, including conducting some further interviews (which then had to be postponed and rearranged because of adverse weather).

Code of Conduct for local authority members - changes to practice

As I reported last year, because of concerns about certain aspects of the Code and the use of complaints for political purposes, I entered discussions with the Welsh Local Government Association (WLGA), the Association of Council Secretaries and Solicitors (ACSeS) and the Welsh Government on a range of measures designed to reform the current Code of Conduct system, which could be achieved without the need for legislation. The aim was that these measures would enable a local resolution process to be introduced across Wales which should greatly reduce the number of complaints brought by councillors against other councillors which need to be considered by my office.

Whilst an 'all-Wales' approach has yet to be adopted, some county councils have introduced such arrangements. Typically these complaints involve paragraph 4(b) of the Code concerning the requirement to show respect and consideration and 6(1)d which sets out the expectation that members will not make frivolous or malicious complaints. Where these arrangements are in place, I will refer appropriate complaints back for local resolution. Many of the issues giving rise to these complaints can best be dealt with locally, and this can help to stop matters from escalating and damaging working relationships. Anecdotal feedback from the councils who have introduced such arrangements are that they are a success and are having the intended effect. This seems to be borne out by the reduction in the number of complaints to my office (as illustrated at page 16), although I recognise that 2011/12 was an election year which would have had a bearing on the level of complaints received.

The other element of the new approach applies to members of county/county borough councils and community/town councils. When I am minded not to investigate a complaint or having commenced an investigation I am minded to close my investigation, I will write to the local Monitoring Officer. This will arise when I judge that even if the Standards Committee did find that there had been a breach of the Code, it would be unlikely to apply a sanction. It will then be for

the Monitoring Officer to consider the matter. If they take a different view on the likelihood of the Standards Committee applying a sanction if they decide that there has been a breach of the Code then I will transfer the investigation to them for local consideration. The year 2012/13 was the first full year of operating this new approach. During the year I referred 37 such complaints to Monitoring Officers, 2 of which were called in for local investigation.

Guidance on the Code of Conduct for Local Authority Members

I originally issued Guidance on the Code of Conduct in April 2010. It was always intended that the Guidance would be a living document, updated to reflect the impact of decisions made by standards committees and tribunals of the Adjudication for Panel for Wales. A significant revision was undertaken and published in September 2012, when I took the opportunity to produce separate versions to reflect the differing circumstances of members of principal councils and members of community councils. I have had very positive feedback on this development, and community councils in particular have appreciated a Guidance document tailored for their own circumstances.

One case during the year which in particular led me to amend the guidance was the Calver case. A High Court judgement on this case had impact on the application of paragraph 4(b) of the Code relating to treating others with respect and consideration. I had always taken the view that robust political debate is an essential part of the democratic process and the judgement helps to more clearly set out where the boundaries lie. Councillor Calver was accused of failing to show respect and consideration for others by posting comments online about other councillors and the way in which the Council was run. My investigation concluded that his conduct was likely to represent a breach of the Code. The Standards Committee agreed, and imposed a censure. Councillor Calver appealed this decision to a tribunal of the Adjudication Panel. This upheld the finding of the Standards Committee and Councillor Calver went on to seek a judicial review of this decision. The Court found that whilst the comments which were posted were sarcastic and mocking and the tone ridiculed his fellow members, because the majority of the comments related to the way in which the Council was run, how its decisions were recorded and the competence of the councillors, the comments were political expression. The ruling said no account had been taken of the need for politicians to have "thicker skins". In view of the Member's freedom of expression and the fact that the majority of comments were directed at fellow councillors, the finding of a breach in this case was a disproportionate interference with the Member's rights under Article 10 of the European Convention on Human Rights. The Standards Committee's decision to censure the Member was therefore set aside.

Mr Justice Beatson was very clear in stating that a member's freedom of expression attracts enhanced protection under the Human Rights legislation when his or her comments are political in nature. 'Political' comments are not confined to those made within the Council chamber and, include, for instance, comments members might make about their authority's policies or about their political opponents.

As a consequence of the judgement I have made clear that it is highly unlikely that I will investigate complaints made about members criticising the policies or performance of their council or indeed, their political opponents. Mr Justice Beatson made clear that councillors need a "thicker skin" in dealing with, and responding to, politically motivated comments.

I have also had to think carefully about what the implications are for comments about officers. When members raise issues which could be considered political with officers, particularly those holding senior positions, such as chief executives or strategic directors, then it is clear that some degree of protection is afforded to members. It is clearly the case that when responding to such issues senior officers will also need a "thicker skin" and should expect to engage in robust discussions with members. However, it is evidently the case that more junior officers will continue to need the protection of the Code and that even with senior officers, there must be a limit on the extent of the legal protection members enjoy. Accordingly, I will continue to consider each case on its merits. I should also say that what is legally permissible, and what is desirable, are not necessarily the same and would urge all members to conduct themselves in a way that continues to promote standards of behaviour, characterised by respect, and which reflect positively on local government.

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

I have previously made clear that I believed the situation in relation to the levels of indemnity enjoyed by members who are accused of a breach needed to be addressed. This is particularly current in the context of the very difficult financial climate in which we are all working. By having unlimited indemnity, it is possible for cases before tribunals to last for months or even longer, with counsel being engaged at very considerable cost. I strongly believe that members should be able to defend themselves, but that public expenditure on this must be proportionate. I proposed a maximum ceiling of £10,000, to reflect the costs ceiling in employment tribunals. In discussions with monitoring officers and the Welsh Local Government Association (WLGA), this ceiling was raised to £20,000, which I was prepared to support. However, while some councils already have such a ceiling in place, and some councils were prepared to introduce one, others have said that they do not intend to do so. In some instances, this is because the indemnity is backed by insurance. The former local government minister indicated that he would address the matter through legislation if voluntary agreement could not be secured. I note that the WLGA have reported that Council Leaders support the introduction of an indemnity cap and I hope that voluntary agreement will be forthcoming. However, I would support the use of legislation if it is not.

5. Improving Public Service Delivery

My main role as an Ombudsman is to consider individual complaints and provide redress for individuals. However, I place great importance on ensuring that we use the learning from complaints to improve public services in Wales.

Public interest reports

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

I issued 10 public interest reports during 2012/13. 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.

'The Ombudsman's Casebook' first introduced in 2010 is now well established. It was developed to reflect the fact that although individual cases of this type may not be of 'public interest', when considered amongst a number of similar complaints and outcomes, there may well be lessons that public bodies can learn from these complaints too. The Casebook is issued quarterly and has a wide circulation which includes bodies in jurisdiction, Assembly Members and voluntary organisations, as well as individuals who have 'signed up' to receive a copy. The feedback that I have been receiving from all quarters concerning this publication has been very positive. So much so that during the past year I also included summaries of quick fixes that we achieved so that the learning from the cases that we resolve informally can also be shared.

A number of topics were addressed in the four digests published during 2012/13 and key issues identified where lessons could be learnt were as follows:

- Health – Consent
- Health - Risk Assessment
- Planning – Enforcement Action
- School Admission Appeals
- Effective communication with complainants

Annual letters

For the third year I issued Annual Letters to county/county borough councils and health boards, which are also published on my website. I have continued to limit issuing such letters to these organisations, as I do not receive the necessary volume of complaints in respect of other bodies to enable meaningful comparisons on an all Wales basis and to identify any trends. In particular, this year they formed a useful basis of discussions in my meetings with the Chairs/Chief Executives of individual local health boards.

Complaint handling by public service providers

I reported last year on the Model complaints policy and guidance issued to public service providers by Welsh Government. Having chaired the group that developed the Model, I take a keen interest in its implementation by public service providers. The feedback I have obtained has been very encouraging. Almost all county/county borough councils have now adopted the Model, as has the Welsh Government. I will be following up progress in respect of other public service providers, such as housing associations, in the forthcoming year.

The above Model and the 'Putting Things Right' complaint handling arrangements in respect of health care mean that the complaint handling procedure in respect of Social Care is now out of step with the rest of the public service in Wales and I have made a case that the existing statutory procedure should also be modernised to bring it in line with the other complaint processes. I have engaged in discussions with the Welsh Government on this matter and I understand that it is intended to introduce a streamlined two stage approach for social care by regulation rather than through the Social Services and Well-being (Wales) Bill. The procedures for handling health complaints and those of the other public services devolved to Wales make provision for a single lead arrangement for dealing with multiple agency involvement. However, with the existing Social Services procedure being out of kilter with the other procedures, doing so in practice currently presents difficulties. I therefore look forward to engaging further with the Welsh Government and other interested parties in the forthcoming year and hope swift progress can be made on bringing the arrangements for social care complaints handling in line.

I was also pleased to be able to work in partnership with the Ombudsman Association and Queen Margaret University, Edinburgh, in hosting the Ombudsman Association's approved Professional Award in Ombudsman and Complaint Handling Practice Accredited Training course in May 2012. The course was attended by complaint handling staff from a number of local authorities, the Welsh Government and the Welsh Language Commissioner's office, as well as staff in my own office.

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 accountable to the National Assembly for Wales, both through the mechanism of this annual report, and as Accounting Officer for the public funds with which the National Assembly entrusts me to undertake my functions.

I particularly welcomed the new arrangements introduced during 2011/12 whereby I had the opportunity to discuss my Annual Report with the Communities, Equality and Local Government Committee. This enabled me to discuss the work of my office and draw attention to the lessons that could be drawn from my investigations with a view to improving the delivery of public services in Wales.

Governance arrangements

Advisory Panel

During 2011/12, I reviewed the governance arrangements of my office, whilst bearing in mind the constitutional position of a corporation sole and the fact that responsibility and accountability for the activities carried out by the office must remain with the Ombudsman. I decided that in order to enhance openness and transparency the office would benefit from the creation of an Advisory Panel in addition to the advisory Audit Committee already in place.

Following an open, public recruitment process I was very fortunate to be able to form a Panel of diverse and high calibre members. The role of the Panel in underpinning excellent governance is to provide support and challenge to me as the Ombudsman.

Members appointed to the Panel are:

- Ceri Stradling (who is also Chair of the Audit & Risk Committee) - a former Senior Partner with the Wales Audit Office
- Margaret Griffiths – Emeritus Professor and former Head of the Law School, University of Glamorgan
- Bill Richardson – former Deputy Chief Executive at the office of the Parliamentary and Health Service Ombudsman
- Jan Williams - former Chief Executive of Cardiff & Vale University Health Board
- John Williams - former Director of Social Services for Conwy County Borough Council.

The Advisory Panel met four times during 2012/13 and is already proving to be helpful in providing an external perspective on the work of the office as well as bringing additional expertise in wider governance matters.

Back row (left to right):
John Williams,
Peter Tyndall,
Ceri Stradling,
Bill Richardson.

Front row (left to right):
Margaret Griffiths,
Jan Williams.

Audit and Risk Committee

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

Although a 'corporation sole', I have an Audit and Risk Committee which is charged with advising me in discharging my duties as Accounting Officer. Mr Ceri Stradling has been appointed as the Chair of the Audit and Risk Committee, subsequent to Mr Laurie Pavelin's term of office ending on 31 March 2012. Professor Margaret Griffiths continues to serve as an independent Member, who brings her considerable legal expertise, particularly in the Welsh context, and the membership has also been strengthened with Mr Bill Richardson joining the Committee. I am also a member of the Committee in my capacity as the Accounting Officer.

The Audit and Risk Committee considers matters including the annual accounts, external and internal audit reports, and risk management issues. The Committee met four times during 2012/13 and I am pleased that no substantive matters of concern were raised during the year.

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

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 Business Plan; annual budgetary requirements; ensuring the best use of the public money received; and an appropriate performance monitoring framework.

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

Three Year Strategic Plan and Business Plan

This past year was the first of the new three year plan developed for 2012/13 to 2014/15. The revised vision, values, purposes and strategic aims set can be found at Annex D. Whilst much of the Plan takes forward the innovations introduced over the past couple of years, there is also focus on preparing for the new areas of jurisdiction which are likely to be introduced to my office as a result of the Social Services (Wales) Bill. An update has now been produced to take us into the second year of the Plan, as has the annual Business Plan for 2013/14, which flows from the Strategic Plan and sets specific targets and performance indicators for the year ahead.

Strategic Equality Plan

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

Complaints Wales signposting service

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

We have continued to develop the service over the past year and in particular have been building on the data we hold on advice and advocacy organisations, including giving summary details on our website of the type of service provided by these bodies.

We have also further enhanced promotional activity in relation to raising awareness of the service. Following the initial leafleting exercise of households in Wales, we began on a radio advertising campaign in 2012/13. The advertisements will continue to be broadcast periodically during 2013/14 and it is intended to support this with other promotional activity in the forthcoming year.

This development has attracted much interest from other ombudsman schemes both within the UK and internationally.

Complainant satisfaction research

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

We have continued with our first contact survey work and the feedback received is pleasing to see. The overall outcome of responses during 2012/13, where service users were asked whether they agreed or disagreed with the statements below is as follows:

	% of respondents answering either 'strongly agree' or 'agree'
It was easy to find out how to contact the Ombudsman's office	82%
The service I have received so far has been helpful and sensitive	82%
Staff were able to understand my complaint / The person that dealt with my query knew enough to be able to answer my questions	87%
I was given a clear explanation of what would happen next to my concern	85%
The service provided what I expected of it	82%

During the course of the year we have also been developing a means of combining our satisfaction survey with our equality monitoring and capturing this on our complaints database. The data will be held confidentially and not accessible to staff involved in complaint handling. As well as for general equality monitoring purposes we will also use the data to monitor any correlation between complaint outcomes and equality status.

We also commissioned Beaufort Research to include a number of questions in one of their Omnibus Wales surveys to understand people's experience of complaining to public bodies and their awareness of various Ombudsmen schemes. The sample was designed to be representative of the adult population resident in Wales aged 16 and over. Three key messages from this research were:

- fewer than a quarter of the respondents had made a complaint to a public body
- and just over half of them were dissatisfied with the outcome of their complaint
- the lowest level of awareness of the PSOW was among the socio-economic group DE (e.g. those in semi/non skilled manual labour, unemployed) and we intend to take this information into account when developing our outreach programme of work for 2013/14.

Information and Communication Technology (ICT)

We continually keep under review our information technology arrangements to ensure that our systems are fit for purpose at a time when our caseload is increasing significantly and new ICT developments are emerging at a frantic pace. During 2012/13 we introduced a three year plan where the aim is to increase efficiency by eliminating the need for hard copy case records and also to improve telephone integration with our other IT systems.

External communication

Social Media: Recognising that it is important in today's world to have a social media presence, the office dipped its toes into the water at the beginning of 2012/13 introducing a Twitter account. To date 'tweets' have been confined to communicating news such as publication of public interest reports and the Ombudsman's Casebook.

Traditional Media: I have been pleased that we have this year again attracted a high level of television and radio coverage (both English and Welsh language), largely as a consequence of the public interest reports that I have issued. There has also been a good level of coverage in the press with 177 articles mentioning the Public Services Ombudsman for Wales.

Outreach: We have also continued with our practice of addressing various voluntary organisations. In particular, we addressed the advice workers of the Citizens Advice Bureau at their regional seminars. I view it of particular importance that we are able to discuss the work of my office directly with those at the frontline of advising members of the public and how they may be able to assist their clients to put complaints to me.

In co-operation with Age Cymru and the Older People's Commissioner, we also held a Delivering Dignity in Care conference in Llandrindod Wells to coincide with the UN International Day of Older Persons and UK Older People's Day.

The outreach work of the office was enhanced by the significant media attention to my investigation reports, referred to above. This helps to raise awareness not only of the issues of concern identified but also of the role of the Ombudsman and is borne out by the increase of calls to the Complaints Advice Team and visits to my website following television and radio appearances in particular.

We also held three regional seminars (North, Mid and South Wales) for the complaints officers of local authorities, housing associations, the Welsh Government and Welsh Government Sponsored Bodies. This enabled discussion on developments in the service provided by my office, to gain feedback on complaints officers' views on the way my office operates and to explore the degree to which the Model Concerns and Complaints Policy and Guidance for service providers in Wales has been adopted and implemented.

Human resources

Despite the increase in complaints received, no changes were introduced over the past year relating to the staffing complement or structure of the office. The organisational structure showing the position as at 31 March 2013 (see page 32) therefore remains the same as that shown last year.

However, it was necessary during the year to consider the implications of the proposals in the Social Services and Well-being (Wales) Bill. Having undertaken an assessment of the likely increase in complaints as a result of the extension to my jurisdiction I deemed it necessary to build into my plans for 2013/14 an additional investigator post (I have also reserved my position to increase the staffing establishment by a further additional post in 2014/15).

The PSOW and the Ombudsman World

As I have stated in previous Annual Reports, I consider the work of the Ombudsman Association (OA) 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. The OA 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 OA Interest Groups.

Last year I referred to the fact that the office was increasingly gaining an international profile. I am particularly pleased that Wales has been asked to host the European Regional Ombudsmen Conference in 2014. This will be only the second time that the conference has been hosted in the United Kingdom and it is a privilege to do so. We will be working with the European Ombudsman in hosting the event. I was pleased to welcome Professor Diamandouros, the current European Ombudsman (see left), and members of his communication team to the office in February. This was an opportunity not only to begin on preliminary arrangements but also to discuss the work of my office.

In March I was also delighted to be able to welcome Dr Peter Kostelka, the Austrian Ombudsman, who is the Secretary General of the International Ombudsman Institute to the office. This afforded the opportunity to discuss ombudsman issues at Welsh, British, European and International levels and was a useful and constructive occasion.

It was also a pleasure to welcome a delegation from ombudsmen offices in South and West Africa to my office. Our visitors came to find out about my role and responsibilities and the way in which we work. This visit was arranged by GMSI, an organisation working mainly in developing countries. I was delighted that subsequently GMSI asked if a member of my staff would deliver some training for investigators at the Ombudsman's office in Lesotho, based on our work. The invitation particularly struck a chord in view of the already well established links between Wales and Lesotho. I received very positive feedback about the success of the training event and we also took much away from the occasion in understanding the challenges faced by the Lesotho Ombudsman and her staff.

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 2012/13 and their outcomes, together with a comparison of the position in 2011/12.

Details of the 'complaints about us' received	**2012/13**	**2011/12**
Not upheld	32	24
Upheld in whole or in part	12	5
Referred back to Investigation Manager or Review Manager (investigation decision related)	10	6
Complaint withdrawn or insufficient information	3	1
Still open at 31 March	2	2
Total received	**59**	**38**

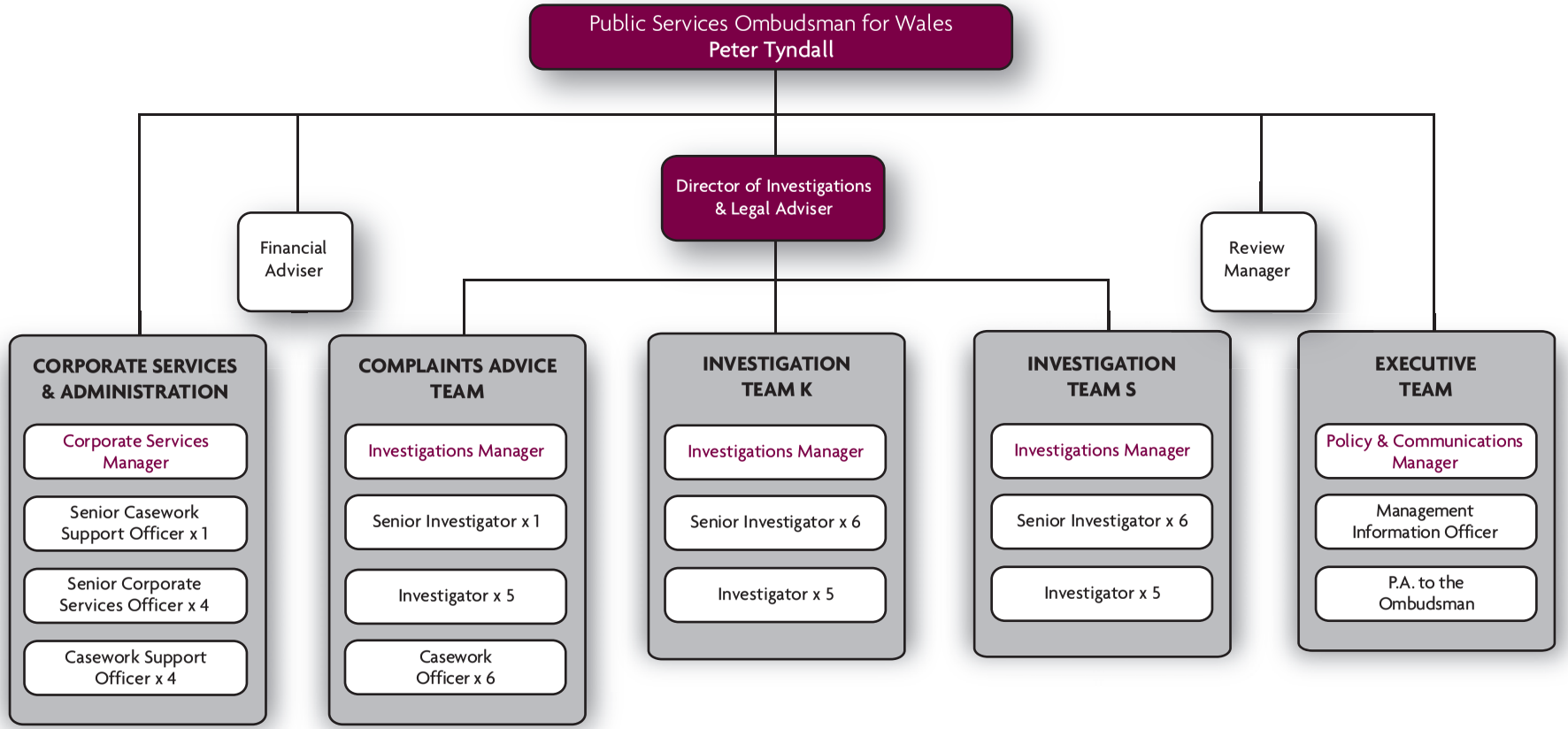
The nature of the complaints that were upheld/partly upheld were:

Accuracy in correspondence (e.g. misspelling of complainant name)	3
Failure to acknowledge receipt of/act on correspondence	3
Lack of attention to the detail contained in correspondence	2
Electronic communication/data issues	4
Total	**12**

An apology was issued in respect of each of the above 12 cases and additionally:

- in 3 cases staff were reminded of processes and procedures
- in 1 case a review of the relevant procedure was undertaken with a view to avoiding future repetition of problem
- in 4 cases corrective action was undertaken.

Organisational Chart (position as at 31 March 2013)



8. Equality Issues

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

Under the Equality Act 2010 and the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 laid down by the National Assembly for Wales, I have a duty to publish a Strategic Equality Plan and equality objectives. The first such Plan, which contains my equality objectives, was published at the end of March 2012 and complied with the statutory requirement to publish before 2 April 2012. (The Plan is available on my website: see www.ombudsman-wales.org.uk). Also under the specific duties, I am required to produce an annual report in respect of equality matters. As articulated in my Strategic Equality Plan, many of our practices have been part and parcel of our approach since the inception of the office in 2006. Where relevant therefore, these will remain a part of my annual report on equality matters, which I set out below.

Accessibility

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

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

When we introduce the version of my websites for mobile devices, we also plan to introduce the version of BrowseAloud specifically designed for tablets and smartphones.

We also recognise that some service users may need assistance in making their complaint to us and we have also invested a great deal of our energy in gathering information about advocacy and advice organisations to help them in this regard. This is also a key source of information in relation to the Complaints Wales signposting service we provide, when members of the public may also want help during the process of complaining to a public body or another complaint handler.

Equality Data Gathering/Monitoring – Service Users

We have always undertaken equality monitoring in respect of service users, which has informed our annual outreach strategy. Results of equality monitoring undertaken since 2005/06 in respect of service users has been published in the Strategic Equality Plan. However, an up-date setting out the position for 2012/13 is provided below (with comparison against the previous two years).

		2012/13	2011/12	2010/11
Gender:	Male	50%	46%	55%
	Female	50%	54%	45%
Age:	Under 18	0%	0%	5%
	Over 65	26%	20%	26%
Minority Ethnic Group		1%	2%	3%
People with Disabilities		38%	34%	27%

We take the results from this monitoring into account when developing our outreach programmes. We will be giving further attention to raising awareness of my service among people from minority ethnic groups during 2013/14.

Our own equality monitoring has been supplemented in the past by equality monitoring questions asked during our customer satisfaction surveys undertaken on our behalf by Opinion Research Services. We have used the evidence from these satisfaction surveys to improve our service. For example, we removed certain barriers such as not always requiring complaints to be made in writing and allowing them to be made by phone, email or through our website. I have referred at page 28 to the work undertaken this past year to enhance our equality monitoring. We will use this intelligence to identify any areas that could improve our customer service, including equality considerations.

Training

My staff have over the years received equality and diversity training. We continue to provide relevant training in this regard. This is important to us for two reasons. Firstly, so that in the service we provide we can be responsive to the changing needs and requirements of people with whom we communicate and interact. For example, during 2012/13 several members of my staff attended training sessions which enable them to produce Easy Read versions of documents. Secondly, so that we have the knowledge to be able to identify during our investigations any failings by public service providers in respect of equality duties.

Outreach

We meet regularly with third sector organisations, holding formal seminars at least biennially, giving talks and addresses at their conferences and we also have an ongoing proactive programme of meeting with individual organisations. This year's activity has been reported on at Section 7 of this Annual Report. This enables two way discussions about the work of the office, so that we can obtain views on the service we provide from their perspective and it enables us to explain how they can help those individuals who require assistance in making a complaint to us to do so.

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

Equality Impact Assessments

As part of the work in developing the Strategic Equality Plan, we developed an equality impact assessment toolkit. Equality Impact Assessments (EIAs) are now embedded in our practices when reviewing existing, or developing new, policies and procedures. For example, we reviewed all of our internal policies and procedures during the year, undertaking EIAs in respect of each and every one of these.

Staff Equality Data Gathering/Monitoring

Up to 31 March 2012, the data and information that we held in respect of staff was limited. During the past year we revised our arrangements for gathering employment information and pay differences so that we hold a central record. Staff were asked to complete and return a monitoring form seeking information in respect of each of the protected characteristics. That disclosure was, of course, on a voluntary basis. Following the monitoring exercise, the data we now hold is as follows:

Age	The composition of staff ages is as follows: 21 to 30: 13% 31 to 40: 32% 41 to 50: 33% 51 to 65: 22%
Disability	83% of staff said they were not disabled, no member of staff said that they were a disabled person (17% preferred not to say) However, when asked if their day-to-day activities were limited because of a health problem or disability which had lasted, or was expected to last, at least 12 months, 2% said that they were limited a lot, 2% said they were limited a little, 79% said their day to day activities were not limited (17% preferred not to say)

Nationality	In describing their nationality, 50% said they were Welsh; 24% said British, 11% said they were English, 2% said 'Other' (13% preferred not to say)
Ethnic group	The ethnicity of staff is: 81% White (Welsh, English, Scottish, Northern Irish, British); 2% White/Irish 4% Black (African, Caribbean, or Black British/Caribbean) 2% Asian or Asian British/Bangladeshi (11% preferred not to say)
Language	When asked about the main language of their household, 78% of staff said this was English; 9% said Welsh, and 2% said 'Other'
Religion or Belief	Responses to the question asking staff about their religion were as follows: No religion: 39%; Christian: 39%; Muslim: 2%; Other: 2% (18% preferred not to say)
Marriage/ Civil Partnership	When asked if they were married or in a same sex civil partnership, 50% of staff replied 'Yes'; whilst 33% said 'No' (17% preferred not to say)
Sexual Orientation	Responding on this, 78% said that they were Heterosexual or Straight, 2% said Gay or Lesbian (20% preferred not to say)

Under the specific duties I am required to set an equality objective for gender and pay; if I do not do so, I must explain why. My Strategic Equality Plan does not currently contain any specific objective in this regard because at the time of its development females were very well represented at the higher pay scales within my office. I have undertaken to keep the situation under continual review and revise my equality objectives if necessary. However, as can be seen from the table on page 37, the position currently remains satisfactory.

Pay and Gender - data as of 31/03/2013

Pay (FTE)	Male	Female
Up to £20,000	0	14
£20,001 to £30,000	0	2
£30,001 to £40,000	5	11
£40,001 to £50,000	7	10
£50,001 to £60,000	1	3
£60,001 +	0	1
Subtotal	**13**	**41**
Total	**54**	

In relation to the working patterns of the above, all staff work on a full time basis, with the exception of six (four female, two male) who work part time.

Procurement

We have also revised our procurement policy over the past year and this now refers to the relevant equality requirements that we expect our suppliers to have in place.

Annex A

Public Body Complaints

Public Interest Reports: Case Summaries

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case reference 201201214 – Report Issued March 2013

Mr B underwent complex bowel surgery in July 2011 with a view to managing unpleasant symptoms. He very sadly died six days later. My investigation considered the following complaints:

- the extent and risks of surgery were not fully explained to Mr B;
- there were insufficient investigations and bowel preparation prior to surgery, and the surgery itself was not appropriate; and
- Mr B's partner was not told of the outcome of surgery until he deteriorated.

The Health Board said that there had been a 'long and detailed consent process'. However, there was no evidence of this. I upheld the complaint and found that Mr B was only made fully aware of the extent of the surgery shortly before he was taken to theatre. I concluded that he was not made aware of all the potential risks involved, and that he went into major surgery, which ultimately led to his death, without having been fully informed or being in a position to give proper consent.

My investigation found a divergence of opinion about whether pre-surgery investigations were needed. None were undertaken. However, it was suggested that Mr B's case should have been discussed within a multi-disciplinary team forum prior to surgery, and I asked the Health Board to consider this.

Having carefully considered all the evidence, I concluded that the surgery was too risky for symptom control only, unless Mr B had wished to proceed on a fully informed basis. I found that the surgeon was acting at the limit of his skills in undertaking such complex surgery. I upheld this complaint. Finally, I found that it would have been good practice for Mr B's partner to have been told of his deterioration sooner than she was and I also upheld this complaint.

I made a number of recommendations to the Health Board which it agreed to implement. These included a payment of £5000 to Mr B's partner for the distress caused by the failings identified, and to acknowledge the uncertainty she lives with over whether Mr B might have lived.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case reference 201200787 – Report Issued March 2013

Mr O had a diagnosis of dementia. He was admitted to Cefn Coed hospital in 2009 and remained there until his death four months later. His daughter, Miss O, complained about aspects of his care towards the end of his life.

Mr O was assessed as 'at risk' of developing a pressure sore. Despite this, he was not re-assessed until after he developed a significant pressure sore two months later. Had assessment and further preventive measures been taken, it is possible that the pressure sore might not have happened.

There was a lack of nutritional assessment, and Mr O was not referred to a dietician. Further, he should have been referred to a Speech and Language Therapist (SALT) for a swallow assessment. Without regular nutritional assessments and without the input of a dietician and SALT, it is reasonable to conclude that the provision of food and fluid to Mr O was not as good as it could have been.

No end of life care pathway was in place at the time of Mr O's death, and his end of life care did not comply with the principles of palliative care. Nor was his pain management reasonable or consistent with guidelines. It therefore seemed likely that his pain management was insufficient on occasions.

My investigation identified patterns of failures to assess (pressure care, nutrition), to refer (to SALT, to a dietician, to palliative care), and to plan (end of life care). My office issued two other reports to the Health Board during the year (case references 201100120 and 201101689) both of which concerned elderly patients and in which some similar failings were identified, albeit at a different hospital and where the events occurred in 2008 and 2011. For that reason, I referred this report to Healthcare Inspectorate Wales for it to take into account in planning its future inspections.

I made a range of recommendations to the Health Board to prevent similar failings happening again. I also recommended that the Health Board apologise to Miss O and her family, and pay her £2000 for the distress exacerbated by failures in care during her father's last weeks of life. The Health Board agreed to implement all my recommendations.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case reference 201103324 – Report Issued February 2013

Mr A complained that there had been a delay in diagnosing and treating Mrs A's, aortic dissection, and that clinicians had failed to communicate with either of them. Mr A also complained about Abertawe Bro Morgannwg University Health Board's ("the UHB") response to his letter of complaint.

Having reviewed all of the information, I found that unreasonable delays had occurred. Despite being aware of Mrs A's medical history, and Mr A's concerns that she was having a heart attack, Mrs A waited at least 35 minutes before any initial tests were undertaken, including any heart monitoring. Following a further wait Mrs A was examined and referred to a Registrar, where she waited an hour to be seen.

The medical notes suggest that following an examination of Mrs A the clinicians suspected that she had an aortic dissection, although there is no evidence to suggest that this information had been shared with Mr or Mrs A. Due to the serious nature of this illness and the high mortality rate, clinicians would be expected to prioritise the tests to diagnose this condition. However in Mrs A's case the clinicians failed to do this, instead tests were undertaken to "rule in" other more common disorders rather than "rule out" the aortic dissection. Sadly, Mrs A passed away shortly after being diagnosed.

Finally, I found that the UHB had failed to respond to Mr A's letter of complaint in accordance with its procedure. I also found that there was no evidence that lessons had been learned and that remedies had been put into place to prevent this occurrence again.

I upheld the complaint and recommended that the UHB should apologise and pay the sum of £5000 to Mr A, and Mrs A's children. I also recommended that relevant staff be reminded of the importance of communication with patients and relatives, and that complaint handlers be reminded of the requirements set out in the UHB's interim complaints policy and procedures. Finally, I recommended that the UHB implement a pathway for treating patients presenting to the Surgical and Medical Assessment Unit with suspected aortic dissection.

Aneurin Bevan Health Board and Care and Social Services Inspectorate Wales – Continuing Care
Case reference 201100737 & 201103665 - Report Issued December 2012

Ms A complained to me about the treatment and care provided to her mother, Mrs X, whilst she was a resident at a Care Home. The Care Home had been contracted by Aneurin Bevan Local Health Board ("the LHB") to provide Mrs X's care on its behalf.

Ms A also complained about CSSIW's actions following the investigation of her complaint. In particular its failure to undertake any enforcement action against the Care Home, and its reference to Ms A's complaint as "resolved" in its annual inspection report, a comment Ms A felt was misleading.

Having reviewed all of the information available I found that Mrs X, a patient of the LHB, expected to be provided with a package of NHS care that met all of her needs in a manner that would promote wellbeing, independence, autonomy and self-worth. However, the evidence available to me suggested that the care provided by the Care Home on behalf of the LHB failed to meet that expectation.

The LHB's contract with the Care Home said that it would undertake contract monitoring, including a reported annual inspection. In my view the monitoring undertaken at the Care Home was ineffective, and the provisions within the contract relating to complaints handling failed to meet the requirements of the NHS Guide to Handling Complaints in Wales 2003. Ms A's complaint about the LHB was upheld.

With respect to Ms A's complaints about CSSIW, I found that the investigation process had been so narrow that serious failings had not been identified. I also found that the CSSIW compliance process was not robust enough in this case to ensure that the service user's basic needs were being adequately met. Furthermore, despite CSSIW recognising that at the time of the investigation and publication of the investigation report, Ms A had not been satisfied with the findings and intended to pursue the matter further, it used the term "resolved" when describing her complaint. This was disingenuous. I partly upheld this part of the complaint.

I recommended that the LHB and CSSIW pay Ms A £500 and £250 respectively as an acknowledgement of the service failure identified in this report. I also made a number of systemic recommendations including a review of policies and procedures for contracted out care.

Cwm Taf Health Board – Clinical treatment in hospital
Case reference 201200624 – Report Issued December 2012

Mrs B complained about Cwm Taf Health Board ("the Health Board") in relation to treatment she received at Prince Charles Hospital in July 2011. Mrs B explained that she fell into a pond and sustained a broken ankle. She said that the Hospital should have transferred her urgently to a specialist centre due to the circumstances and severity of the fracture. She added that the treatment she received at the Hospital was inappropriate and led to her having to have an amputation of her lower leg after she was belatedly transferred.

I concluded that an immediate transfer was not necessary. However, I found that due to the possibility of marine type infection, the Hospital should have taken urgent microbiological advice. I found that once the wound was infected, an urgent transfer to a specialist centre should have occurred. I also had concerns about the supervision of the junior surgeons who operated on Mrs B's ankle.

I recommended that the Health Board pay Mrs B £3000 as an acknowledgement of the injustice she suffered because of the Health Board's failings. I also made a variety of systemic recommendations including de-briefing activities, record keeping and supervision of junior surgeons. The Health Board accepted my recommendations.

Cwm Taf Health Board– Clinical treatment in hospital
Case reference 201101484 – Report Issued November 2012

Mrs J, the daughter of the late Mrs Y, complained to Cwm Taf Health Board about the clinical investigations and treatment provided to her mother when she attended the Accident & Emergency Department on 13 May, and the Medical Day Unit at Royal Glamorgan Hospital on 14 May 2010. Sadly, Mrs Y died following her discharge on 16 May 2010. Pulmonary thromboembolism was recorded as the principal cause of death.

Mrs J complained that the clinicians treating her mother failed to take timely and appropriate action in response to a blood test result which indicated thrombosis. Mrs J considers that had prompt action been taken when the result was available on 14 May 2010, her mother's death may have been prevented.

My investigation found that the test was viewed by a nurse before Mrs Y's discharge on 14 May. Mrs Y's blood result was positive. A positive result can indicate thrombosis. The test result does not appear to have been appropriately considered, if at all, by the doctor who made the decision to discharge Mrs Y or by the Consultant with overall responsibility for her care before her discharge.

I concluded that the failure to consider and act upon the positive blood test result before making the decision to send Mrs Y home fell below an acceptable standard of care. This failing gave rise to a missed opportunity to make the correct diagnosis and to treat Mrs Y appropriately. The treatment that should have been given might have prevented her death. The investigation also identified a number of additional failings on the part of the Health Board.

I upheld the complaint and recommended that the Health Board should provide explanations and an apology to Mrs J and her family in addition to a redress payment of £5000.

Hywel Dda Health Board– Clinical treatment in hospital
Case reference 201102690 – Report Issued September 2012

Mrs F complained about matters concerning her daughter's treatment at one of Hywel Dda Health Board's hospitals in 2011. She explained that her daughter, Miss F, had a severe form of endometriosis, which is a gynaecological condition. Mrs F said that the hospital mismanaged her medical care, failed to refer onward to a more specialist hospital in another area and mishandled her complaint.

I upheld her complaints. I noted that the hospital had operated on Miss F twice. The second operation was poorly planned and Miss F was badly prepared psychologically and physically. Moreover, she should have been referred to a more specialist unit after the first operation. In the event, Miss F's second operation was abandoned without success and clinicians decided to refer her to the other hospital. I concluded that the hospital played a part in the referral initially failing. In addition, I criticised the Health Board concerning the handling of Mrs F's complaint.

I recommended that the Health Board apologise to Miss F and pay her £3250 as an acknowledgement of the injustice she suffered due to the failings identified. This included an unnecessary operation. I made a number of further recommendations including work to ensure that patients are prepared properly for gynaecological operations, action to prevent a recurrence of the planning failures in Miss F's case and improving referral pathways. The Health Board accepted my recommendations.

Betsi Cadwaladr University Health Board– Clinical treatment in hospital
Case reference 201101271 – Report Issued August 2012

Mrs A complained about the care given to her late father, Mr Y, when a patient at Glan Clwyd hospital in 2009. She said that there were delays in his diagnosis and treatment. Sadly Mr Y died on 7 November 2009 following extensive surgery to drain a perianal abscess and treat the quickly progressing and very serious infection which developed.

I upheld Mrs A's complaint. I found that delay in diagnosis and in carrying out surgery were significant factors in Mr Y's death. My main findings were:

- the lack of a review by a consultant urologist;
- failure by doctors to record consistently and act upon significant test results to review the initial diagnosis;
- poor communication between medical staff and with the family. There were missed opportunities to obtain information from the family, given that Mr Y had Alzheimer's disease and communication difficulties;
- no overall plan of nursing care for Mr Y and a failure to reassess as his condition deteriorated;
- a criticism of the decision not to carry out surgery late at night and the lack of direct dialogue between the consultant anaesthetist and consultant surgeon.

The Health Board agreed to make a payment of £3000 for the trauma caused to the family for the distressing way in which Mr Y died and the knowledge that the delays contributed to the sad outcome. I made a range of recommendations for the review of procedures, audit and training. My recommendations were accepted by the University Health Board.

Hywel Dda Health Board– Clinical treatment in hospital
Case reference 201100456 – Report Issued April 2012

Ms R complained about Hywel Dda Health Board. Her complaint related to treatment that her late father received at Bronglais Hospital ("the Hospital") in December 2008 and subsequent events. Ms R said that her father was admitted to Hospital after becoming unwell aged 80 years. Among other matters, Ms R complained that the Hospital failed to record important information about his diabetic regime and did not monitor his blood sugar properly. She added that there was evidence to suggest that nursing staff amended the records of her father's blood sugar monitoring to hide their failures. Ms R explained that sadly her father had a hypoglycaemic attack during the period of poor monitoring, which she believed contributed to a cardiac arrest. Her father died a few months later. Ms R added that the response to her complaint by the predecessor body to the Health Board, and later the Health Board, was not robust.

I upheld Ms R's complaint. I concluded that the Hospital did not record and therefore act upon, important details about her father's diabetic regime and failed to monitor his blood sugar levels properly. I found that the hypoglycaemic attack, to which the Hospital's failings contributed, had an unspecific causal effect on the patient's subsequent cardiac arrest and deterioration. I also concluded that there appeared to be a deliberate attempt to cover up the lack of blood sugar monitoring. I found the internal complaint investigations, that took place before my office's involvement, were inadequate.

I made a number of recommendations to the Health Board. These included paying Ms R and the family a total of £1700 as an acknowledgement of the uncertainty and distress over how the failings might have contributed to her father's demise and the extensive time that they had spent pursuing the complaint. I also recommended various systemic reviews, audits and training. The Health Board undertook to implement my recommendations.

Annex B

Public Body Complaints

Statistical Breakdown of Outcomes by Public Body

COUNTY/COUNTY BOROUGH COUNCILS

County/County Borough Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Blaenau Gwent	3	4	6		1		1	1		**16**
Bridgend	6	9	10		1		1			**27**
Caerphilly	6	9	15	1	2		3	1		**37**
Cardiff	12	39	26		13		2		1	**93**
Carmarthenshire	6	16	14	2	7		4	1	1	**51**
Ceredigion	4	5	14	1	2			2	1	**29**
Conwy	3	10	9		2		1	1		**26**
Denbighshire	1	16	15		2		2	1	2	**39**
Flintshire	5	14	12	1	8		1		1	**42**
Gwynedd	4	11	9		2		3		1	**30**
Isle of Anglesey	4	7	11				2	1		**25**
Merthyr Tydfil	4	9	5		1					**19**
Monmouthshire	4	7	8	1	2		1		1	**24**
Neath Port Talbot	3	17	13		1			1		**35**
Newport	5	5	5		1				2	**18**
Pembrokeshire	6	17	19		4		2	1		**49**
Powys	4	14	18	1	7		4		1	**49**
Rhondda Cynon Taf	5	22	17		1		2			**47**
The City and County of Swansea	5	14	20	1	7		1		2	**50**
The Vale of Glamorgan	5	11	13		2					**31**
Torfaen	5	3	11					2	1	**22**
Wrexham	6	15	13		3		2		1	**40**
TOTAL	**106**	**274**	**283**	**8**	**69**		**32**	**12**	**15**	**799**

OTHER LOCAL AUTHORITY

Other Local Authority	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Schools Admissions/Exclusion Appeal Panels										
Admission Appeals Panel - St Brigid's School				1						**1**
Admissions Appeal Panel - Cardiff High School			1							**1**
Admissions Appeal Panel - Glan Usk Primary School			1							**1**
Admissions Appeal Panel - Hendredenny Park Primary School			3							**3**
Admissions Appeal Panel - Rhydypenau Primary School			1							**1**
Admissions Appeal Panel - St Joseph's Roman Catholic Infant School							1			**1**
Admissions Appeal Panel - Ysgol Bro Eirwg			1							**1**
Admissions Appeal Panel - Ysgol Bryn Onnen								2		**2**
Admissions Appeal Panel for Mount Pleasant Primary School									1	**1**
Exclusion Appeal Panel, John Beddoes School					1					**1**
Total			**7**	**1**	**1**		**1**	**2**	**1**	**13**

OTHER LOCAL AUTHORITY (CONTINUED)

Other Local Authority	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
National Park Authorities										
Brecon Beacons	2	3	3	1						**9**
Pembrokeshire Coast	2	2								**4**
Snowdonia	1	2	1					1		**5**
Total	**5**	**7**	**4**	**1**				**1**		**18**
Fire and Rescue Service										
Mid and West Wales Fire Service	1				1					**2**
North Wales Fire & Rescue Authority	1									**1**
Total	**2**				**1**					**3**
Police										
Dyfed-Powys	2									**2**
Total	**2**									**2**

COMMUNITY/TOWN COUNCILS

Community/Town Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Brymbo Community		1	1							**2**
Caerwent Community									1	**1**
Cefn Community		1								**1**
Herbrandston Community			1							**1**
Langstone Community			1							**1**
Llanddowror Community							1			**1**
Llanfynydd Community [Carmarthenshire]		1								**1**
Llangoed a Penmon Community			1							**1**
Llantrisant Community			1		1					**2**
Machynlleth Town			1							**1**
Manorbier Community			1							**1**
Mawr Community	1									**1**
Neath Town					1					**1**
Pontardawe Town			1							**1**
Rogerstone Community			1							**1**
Rogiet Community		1								**1**
St Asaph Community		1								**1**
St Florence Community		1								**1**
Tredegar Town		1								**1**
Total	**1**	**7**	**9**		**2**		**1**		**1**	**21**

REGISTERED SOCIAL LANDLORDS

Registered Social Landlord (Housing Association)	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Bro Myrddin Housing Association Ltd			2							**2**
Bron Afon Community Housing Ltd	1	4	3		1		1			**10**
Cadwyn Housing Association Ltd			2							**2**
Cardiff Community Housing Association Ltd		1	4							**5**
Cartrefi Conwy		3								**3**
Cartrefi Cymunedol Gwynedd		7	2		1					**10**
Charter Housing Association	1	4	2		1					**8**
Clwyd Alyn Housing Association Ltd		1	2		2					**5**
Coastal Housing Group Ltd		1	2							**3**
Cymdeithas Tai Clwyd Cyf		2	1		1					**4**
Cymdeithas Tai Eryri		1					2			**3**
Cynon Taf Community Housing		1								**1**
Family Housing Association (Wales) Ltd		2	1							**3**
Grwp Gwalia Cyf Ltd		2	2		1					**5**
Gwalia Rest Bay (Co-ownership Equity Sharing) Housing Association Ltd		1								**1**
Hafod Housing Association		3	1		1					**5**
Linc-Cymru Housing Association		1	3		1					**5**
Melin Homes Ltd			1							**1**
Merthyr Valleys Homes		5	3		2					**10**

REGISTERED SOCIAL LANDLORDS (CONTINUED)

Registered Social Landlord (Housing Association)	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Monmouthshire Housing Association		8	4		1					**13**
Newport City Homes	4	3	3		1					**11**
Newydd Housing Association		1	1		1					**3**
North Wales Housing	1									**1**
NPT Homes	1	8			1					**10**
Pembrokeshire Housing Association Ltd		1	1		1					**3**
RCT Homes	1	3					1			**5**
Rhondda Cynon Taf Care and Repair			1							**1**
Rhondda Housing Association Ltd		2			1				1	**4**
Seren Group		2								**2**
Taff Housing Association		2	1		1					**4**
Tai Calon	1	3	2							**6**
Tai Ceredigion Cyf		3			1			1		**5**
United Welsh Housing Association	1	4			1				1	**7**
Valleys To Coast	1	3	1							**5**
Wales and West Housing Association		2	5		2					**9**
Total	**12**	**84**	**50**		**22**		**4**	**1**	**2**	**175**

NHS TRUSTS AND LOCAL HEALTH BOARDS

LHB/Trust	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abertawe Bro Morgannwg University Health Board	6	19	23		12	3	19	5	1	**88**
Aneurin Bevan Health Board	5	18	16		6	1	18	2		**66**
Betsi Cadwaladr University Health Board	5	28	24	1	18	1	18	7	1	**103**
Cardiff and Vale University LHB	4	18	27	1	17		20	6	1	**94**
Cwm Taf Local Health Board		16	17	4	2	2	10	5		**56**
Hywel Dda Local Health Board	2	21	19		12	2	8	5	3	**72**
Powys Teaching LHB		5	2	1	5		1			**14**
Public Health Wales	1		1							**2**
Velindre NHS Trust			1							**1**
Welsh Ambulance Services NHS Trust		2	6		3		3			**14**
Total	**23**	**127**	**136**	**7**	**75**	**9**	**97**	**30**	**6**	**510**

OTHER HEALTH BODIES

Health Body	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Dentist		4	6	1	2		4	2		**19**
GP	3	18	26	2	3		19	20		**91**
Cardiff and Vale of Glamorgan Community Health Council			1							**1**
Cwm Taf Community Health Council		1								**1**
Pharmicist		1	2							**3**
Total	**3**	**24**	**35**	**3**	**5**		**23**	**22**		**115**

INDEPENDENT HEALTHCARE PROVIDER

Health Body	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Primecare		1								**1**
Total		**1**								**1**

WELSH GOVERNMENT AND WELSH GOVERNMENT SPONSORED BODIES

Welsh Government and Welsh Government Sponsored Bodies	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Welsh Government										
CAFCASS Cymru	3	6	2		1		3			**15**
CSSIW		1	3		1	1				**6**
Healthcare Inspectorate Wales									1	**1**
Independent Complaints Secretariat			1							**1**
National Institute for Social Care and Health Research	1		1							**2**
Planning Inspectorate	1	1	5				1			**8**
Welsh Government	4	6	8	1			1			**20**
Total	**9**	**14**	**20**	**1**	**2**	**1**	**5**		**1**	**53**
Welsh Government Sponsored Bodies										
Cadw			1							**1**
Care Council for Wales	1									**1**
Environment Agency	1	4	2							**7**
West Wales Valuation Tribunal			1							**1**
Total	**2**	**4**	**4**							**10**
OVERALL TOTAL WELSH GOVERNMENT AND ITS SPONSORED BODIES	**11**	**18**	**24**	**1**	**2**	**1**	**5**		**1**	**63**

OTHER

Other	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
ESTYN			2							**2**
North & Mid Wales Trunk Road Agency		1								**1**
Body not in jurisdiction - not previously decided	2									**2**
Total	**2**	**1**	**2**							**5**

Annex C

Code of Conduct Complaints:

Statistical Breakdown of Outcomes by Local Authority

COUNTY/COUNTY BOROUGH COUNCILS

County/County Borough Councils	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Blaenau Gwent	4		1	1				**6**
Bridgend	2		1					**3**
Caerphilly	4		1				1	**6**
Cardiff	2		1					**3**
Carmarthenshire	6	1	2	1				**10**
Ceredigion	1			2		1		**4**
Conwy	2							**2**
Denbighshire	4							**4**
Flintshire	4							**4**
Gwynedd	4	2			1			**7**
Isle of Anglesey	5						1	**6**
Merthyr Tydfil	7		2			1		**10**
Monmouthshire	2	1	1		1			**5**
Neath Port Talbot	2				1			**3**
Newport	1						1	**2**
Pembrokeshire	3				1			**4**
Powys	4				1			**5**
Rhondda Cynon Taf	11		1				2	**14**
The City and County of Swansea	34	1	6				2	**43**
The Vale of Glamorgan	1							**1**
Torfaen	4			3	1			**8**
Wrexham	11	1						**12**
Total	**118**	**6**	**16**	**7**	**6**	**2**	**7**	**162**

COMMUNITY/ TOWN COUNCILS

Community/ Town Councils	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Bangor City	1							**1**
Beguildy Community	18							**18**
Bodelwyddan Community	2							**2**
Brecon Town	1							**1**
Buckley Town	1							**1**
Caldicot Town	1	1						**2**
Carmarthen Town	2							**2**
Clydach Community	1	1						**2**
Coedpoeth Community						2		**2**
Crickhowell Town	2							**2**
Cwmbran Community							1	**1**
Disserth and Trecoed Community	2							**2**
Dyffryn Ardudwy a Thalybont Community	2			1				**3**
Gorseinon Town	2				1			**3**
Herbrandston Community	2							**2**
Johnston Community	1							**1**

COMMUNITY/ TOWN COUNCILS

Community/ Town Councils	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Kerry Community	4							**4**
Knighton Town	1							**1**
Llandegla Community		4						**4**
Llandovery Town	2							**2**
Llandrindod Wells Town	2							**2**
Llandudno Town					1			**1**
Llanfair Mathafarn Eithaf Community	1							**1**
Llangan Community	2							**2**
Llangernyw Community	1							**1**
Llangoed a Penmon Community	1		1					**2**
Llangynwyd Lower Community	8	2						**10**
Llangynwyd Middle Community	1							**1**
Llantrisant Community						1		**1**
Llantwit Major Town	6							**6**
Maesteg Town	1				1			**2**
Monmouth Town	1							**1**
Mumbles Community	2						1	**3**

COMMUNITY/ TOWN COUNCILS (CONTINUED)

Community/ Town Councils	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Nantyglo & Blaina Town	1							**1**
Old St. Mellons Community	1							**1**
Penmaenmawr Town				1			2	**3**
Penmynydd and Star Community					6			**6**
Pennard Community	6							**6**
Porthcawl Town	1		1					**2**
Prestatyn Town	68	2						**70**
Pyle Community	3						1	**4**
Resolven Community		1						**1**
Rogiet Community	5							**5**
Seven Sisters Community	1							**1**
St Donats Community	1							**1**
St Harmon Community	2			1				**3**
Trellech United Community	1	1						**2**
Tywyn Town	1		1					**2**
Van Community	1							**1**
Wick Community				1				**1**
Ystalyfera Community	1							**1**
Total	**164**	**12**	**3**	**4**	**9**	**3**	**5**	**200**

NATIONAL PARK AUTHORITIES

National Park Authority	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Brecon Beacons			3	4				**7**
Total			**3**	**4**				**7**

POLICE AUTHORITIES

Police Authority	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Gwent			1					**1**
North Wales	1							**1**
Total	**1**		**1**					**2**

Annex D

Extract From Strategic Plan 2012/13 to 2014/15

Vision, Values, Purposes and Strategic Aims

Our Vision

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

Our Values

Accessibility – we will be open to everyone and work to ensure that people who face challenges in access are not excluded. We will be considerate, courteous, respectful and approachable, and do our best to communicate with complainants in the way they tell us they prefer.

Fairness – we will safeguard our independence and reach decisions objectively having carefully considered the evidence.

Learning – we will improve through learning from our own experiences and encourage all public service providers to learn from their own experiences and those of others.

Effectiveness – we will make sure that we work in ways that make the best use of the public money we receive.

Being a good employer – we are committed to providing a positive environment in which to work and to continue to develop and support our staff, to ensure that we continue to remain professional and authoritative in all that we do.

Our Purposes

- To consider complaints about public bodies.
- To put things right. When we can, we will try 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 so that public bodies can learn the lessons from our investigations and put right any systemic weaknesses identified, leading to continued improvement in the standards of public services in Wales.
- To help people send their complaint to the right public service provider or complaint handler.
- To consider complaints that members of local authorities have broken the code of conduct.
- To build confidence in local government in Wales by promoting high standards in public life.

Strategic Aims

Strategic Aim 1: To offer a service where excellent customer care is at the forefront of all we do, where we work to raise awareness of our service and do our best to make sure it is accessible to all and easy to use.

Strategic Aim 2: To deliver a high quality complaints handling service, which considers and determines complaints thoroughly but proportionately, and conveys decisions clearly.

Strategic Aim 3: To use the knowledge gained from our investigations to contribute to improved public service delivery and to inform public policy.

Strategic Aim 4: To continue to analyse and improve the efficiency and effectiveness of our governance, business processes and support functions, to further demonstrate transparency and ensure the best use of the public money entrusted to us.

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 01656 641150
Fax: 01656 641199
E-mail: ask@ombudsman-wales.org.uk
Follow us on Twitter: @OmbudsmanWales

This document is printed on 100% recycled paper. It is available for downloading from the website: www.ombudsman-wales.org.uk