Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

MAKING **A DIFFERENCE**

ANNUAL **REPORT** 2013/14

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

The Annual Report 2013/14

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 by the Acting Ombudsman

Margaret Griffiths
Acting Ombudsman
(from December 2013)

Peter Tyndall
Ombudsman
(to November 2013)

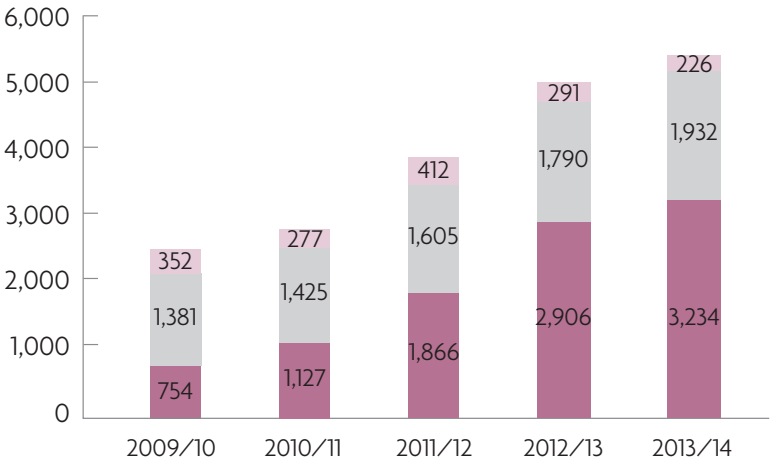
This is the eighth Annual Report of the Public Services Ombudsman for Wales (PSOW) since the inception of the office in April 2006. I am pleased to introduce this report for the year 2013/14 as Acting Ombudsman, having taken on the role in December 2013.

I was appointed as Acting Ombudsman following Peter Tyndall's departure at the end of November 2013, when he left to take up a new role as Irish Ombudsman and Information Commissioner. I will remain as Acting Ombudsman until such time as the new Ombudsman is able to take office.

The Public Services Ombudsman for Wales is appointed by the Crown on the recommendation of the National Assembly for Wales. Nick Bennett – currently the Chief Executive of Community Housing Cymru – has been nominated by the National Assembly for Wales as the next Public Services Ombudsman for Wales. At the time of writing, royal approval for Mr Bennett's appointment is being sought.

An ever-increasing caseload

The upward trend in enquiries and complaints to this office has been a recurrent theme in the Annual Reports of previous years; 2013/14 is no different. As the chart (below) demonstrates, the past year saw another notable rise. Looking back over a period of five years the office has seen a 117% increase in all contacts (that is, enquiries, public body complaints, and complaints about the conduct of members of local authorities).



Total Enquiries and Complaints received by year

- Enquiries
- Public Body Complaints
- Code of Conduct Complaints

It is a tribute to the staff of this office that they have 'held their own' in dealing with cases in a timely way, not only in the face of the continued increase in caseload but also during what has been an unsettling period for them in the latter part of the year, with the departure of the Ombudsman, the appointment of an Acting Ombudsman, and anticipation of the appointment of the new, permanent Ombudsman. I will take the opportunity here to thank all of the staff of the office for making me feel so welcome, for their professionalism, and for the support that they have provided to me since taking up my role as Acting Ombudsman.

The increase in complaints received is a matter of concern. Health complaints continue to be at the core of that concern, having increased by another 11% on the position at the end of 2012/13, and being a 146% increase over the past five years. The rise can be attributed to a number of factors: a reflection of the increased number of episodes of procedures and treatments available giving rise to a greater scope for things to go wrong; people's increased expectations together with a greater propensity to complain; and local health boards and trusts not responding appropriately to a proportion of those complaints (a matter I address further below). However, there can be no denying that it is also an indication that increasingly health service delivery is not what it should be.

However, another area of concern this year has been the increase in social services complaints. Although starting from a much lower base in terms of number of complaints compared to health, there was a 19% increase in social services complaints against the position in 2013/14. It is timely to reflect on this situation now, before the introduction of the new areas to the Ombudsman's jurisdiction as a result of the Social Services and Well-being (Wales) Bill and the changes to the statutory social services complaints procedure. It will be important when monitoring the level of social services complaints to this office not to automatically assume that any increases are merely due to these jurisdictional changes.

Making a Difference

Statistics by their very nature are somewhat impersonal. It is crucial that we do not lose sight of the human experiences that lie behind them. Every complaint equates to a person who has felt aggrieved in some way about public service delivery. The summaries of our public interest reports (see Annex A) give some perspective on this.

Over and above putting things right for the individual we also seek to make a difference through driving improvement in public service delivery by sharing the lessons from our investigations. Our public interest reports and the Ombudsman's Casebook are key tools in this aim, with the latter being well received by bodies in jurisdiction in particular.

The casework of this office can be a good barometer. It can indicate where the pressures lie in public service delivery, as evidenced in the rise of the health complaints for example. We have a unique overview of public service delivery in Wales derived from the views of members of the public who have been dissatisfied with the service they have received. Whilst we respond to National Assembly

and Welsh Government consultations where that is appropriate, public policy makers are encouraged to proactively engage with this office so that any indicators or lessons from our casework can be taken into consideration at an early stage.

The complaint handling landscape in Wales

The PSOW has over a number of years promoted the concept that all public service providers in Wales should adopt a common approach to dealing with complaints. The NHS's 'Putting Things Right' procedure and the Model Concerns and Complaints policy were developed in tandem and both use a two stage process (one informal stage and one formal investigation stage), with complainants, if remaining unhappy, then being able to complain to the Ombudsman. We welcome the fact that the last jigsaw piece to this common approach landscape will soon be slotted into place. In particular, this will now enable complaints involving more than one public service provider to be dealt with effectively, with complainants receiving one comprehensive response from the service provider which has taken the lead on co-ordinating the multi-faceted complaint investigation.

The way complaints are being handled, particularly health complaints, has featured prominently in public discussion during 2013/14. It is the clear view of this office that it is not with the process itself that the problem lies. Rather, it lays with the culture within health bodies and their attitude towards dealing with complaints. Some health boards are insufficiently resourced and there is often a lack of active backing for those managing complaints from senior managers and boards. This means that complaint handling staff are sometimes unable to secure appropriate and timely responses from those who are parties to the subject of the complaint under investigation. The investigations undertaken by this office have time and time again revealed occasions where complaints have not been dealt with in a sufficiently robust manner; for example, independent clinical expertise has not been sought when cases are sufficiently serious in their nature to warrant it. There is also a need for health board members to provide suitable challenge to management and to hold senior managers to account for not responding promptly and appropriately to any identified failures.

Finally, the oversight of the complaints function across public service providers in Wales is limited. During 2013/14, it was not possible to gather comparable statistics on numbers, types or outcomes of complaints made to county/county borough councils or health boards. Both Putting Things Right and the Model Concerns and Complaints Policy make provision for this. However, such data is not currently being collected or analysed at an all-Wales level. This is a valuable source for greater understanding of how well services are being delivered by various bodies, offering opportunities to learn from each other, and indeed to understand how these bodies are dealing with complaints. This is something that the Welsh Government, and the National Assembly for Wales with its scrutiny role, may wish to reflect upon.

Future considerations

Towards the end of his time in office, Peter Tyndall set out his view that, with the tenth anniversary of the establishment of the Public Services Ombudsman (Wales) Act 2005 on the horizon, it was timely to review the legislation under which the Ombudsman operated. He pointed to a number of areas which warranted consideration - for example 'own initiative' powers, which are now common amongst the remits of ombudsmen in Europe and elsewhere in the world. These views are ones that I share, and I hope that the National Assembly for Wales will give further consideration to the proposal that the Act should be reviewed.

Consideration will also need to be given to the implementation of the European Union Consumer Alternative Dispute Resolution (ADR) Directive (implementation date is July 2015). The Directive imposes a requirement on EU member states to offer effective access to ADR services for resolving contractual disputes between consumers and businesses concerning the sale of products and services. The Ombudsman Association has been giving this issue close attention. Although responsibility for meeting the requirements of the Directive largely falls to the UK Government, it is also something that we need to give attention to in Wales, including in the context of the possibility of greater devolved powers to the National Assembly.

Peter Tyndall

Finally, I wish to end this introduction by paying tribute to my predecessor, Peter Tyndall. He undertook his role with commitment and integrity, and ensured his independence as Ombudsman. He developed an efficient office, which was crucial in the face of the increasing caseload. He also introduced and facilitated a number of innovations in the complaints handling landscape. These gained recognition within the international Ombudsman community, but more importantly they have made the process of complaining to, and about, public services easier for people living in Wales.

Margaret Griffiths
Acting Ombudsman

2. The Role of the Public Services Ombudsman for Wales

The Public Services Ombudsman for Wales has two specific roles. The first is to consider complaints made by members of the public that they have suffered hardship or injustice through maladministration or service failure on the part of a body in 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

The bodies that come within jurisdiction are generally those that provide public services where responsibility for their provision has been devolved to Wales. More specifically, the organisations the Ombudsman 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 about public bodies in Wales, the Ombudsman looks 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. Attention will also be given as to whether the public body has acted in accordance with the law and its own policies. If a complaint is upheld the Ombudsman will recommend appropriate redress. The main approach taken 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 the investigation the Ombudsman sees evidence of a systemic weakness, then recommendations will be made with the aim of reducing the likelihood of others being similarly affected in future.

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

The Public Services Ombudsman (Wales) Act 2005 provides two ways for reporting formally on 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 the Ombudsman does not consider the public interest requires a section 16 report (and provided the body concerned has agreed to implement any recommendations made) findings can be issued 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, the Ombudsman needs 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 section16 of the Act, even though it is not a public interest report, and the Ombudsman makes a direction under section 17 of the Act. There were five such reports issued during 2013/14.

The Public Services Ombudsman (Wales) Act 2005 also gives the Ombudsman 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. We have been keen to see greater use made of this power over recent years and seek to identify as many cases as possible that may lend themselves to this kind of resolution (see page 15 for further details).

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

The Ombudsman's 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. This type of complaint is investigated 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 it is decided that a complaint should be investigated, the Ombudsman can arrive at one of four findings:

(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, the Ombudsman is required to submit the investigation report to the standards committee or a tribunal of the Adjudication Panel for Wales and it is for them to consider the evidence 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 3.234 enquiries, **up 11%** on 2012/13.
- We received 1,932 new complaints, **up 8%** on 2012/13.
- We achieved 214 quick fixes/voluntary settlements, **up 21%** on 2012/13.
- We issued 245 investigation reports, **up 2%** on 2012/13.
- We closed 1,926 cases, **up 12%** on 2012/13.
- We had 393 cases on hand at 31 March 2014, **up 3%** on 2012/13.
- We had 1 investigation more than 12 months old open at 31 March 2014.

Caseload – overall position

The number of complaints about public bodies that we receive continues to increase. As the figures in the table below indicate, the overall level of new complaints has increased by 8% compared to the position for 2012/13.

	Total Number of Complaints
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 carried over from 2012/13 (includes Code of Conduct complaints)	382
New public body complaint cases 2013/14	1,932
Total complaints 2013/14	**2,314**
Cases to be carried forward to 2014/15 (includes Code of Conduct Complaints)	**393**

In addition, the office dealt with 3,234 enquiries during 2013/14, compared with 2,906 the previous year.

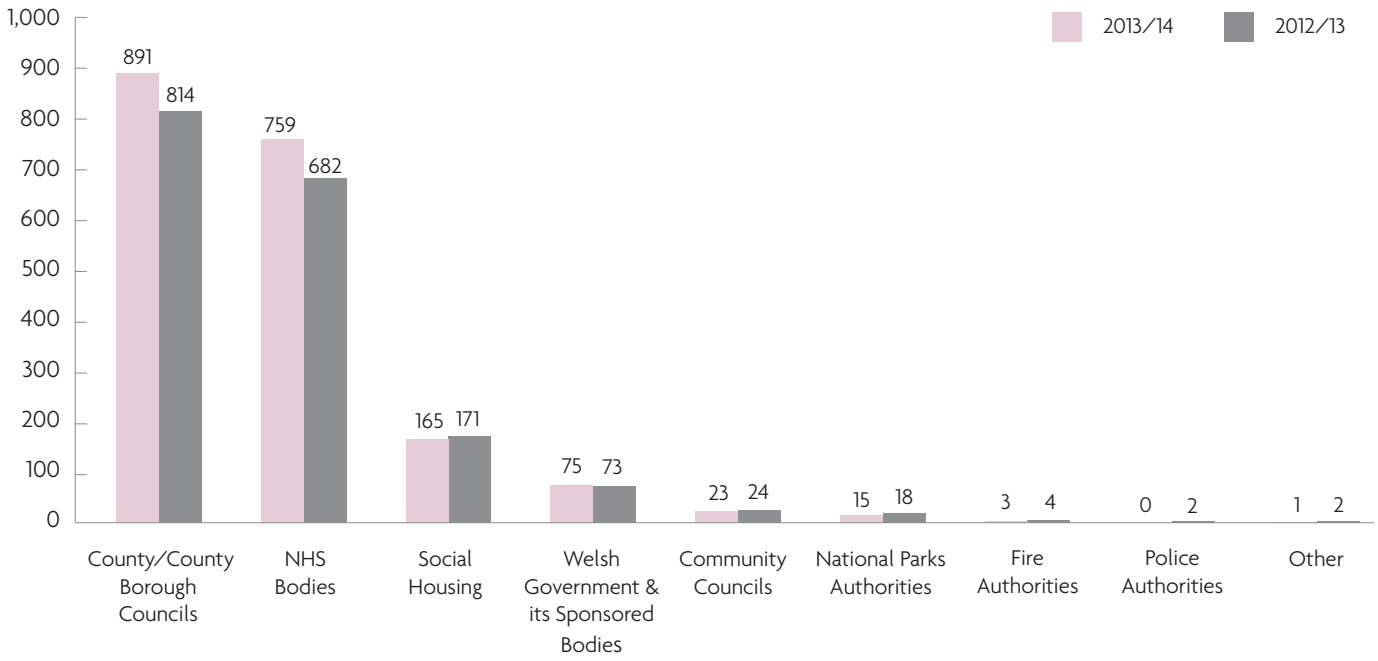
The number of complaint cases on hand at the end of 2013/14 stood at 393 (compared with 382 at the end of 2012/13). As a caseload on hand at any one time, this level is considered to be manageable; that it has been achieved against a background of a continued growth in both complaints and enquiries to the office is a testament to the dedication and commitment of the PSOW's staff.

Sectoral breakdown of complaints

The chart below shows the trends in complaints received per sector. The county council sector has always been the one which has generated the most complaints to this office. As has previously been pointed out, this is not necessarily surprising in view of the wide range of services that these councils provide. However, whilst high in number, complaints received about county councils had held at a fairly constant level over recent years and last year it was good to be able to report that there had been a slight decline. It is disappointing therefore that there has been a notable (9.5%) increase in complaints about this sector over the past year.

Also clear from the chart below is the increase in NHS complaints, which continues the significant upward trend of recent years. There was an 11% increase over the past year (759 complaints compared with 682 in 2012/13). Whilst the continued higher profile of the office, particularly in relation to its role in considering health complaints, can partly attribute for the increase, it must be deduced that the main cause is greater dissatisfaction in health service provision by those in receipt of it, with health boards then failing to deal with the complaints made to them in an effective manner.

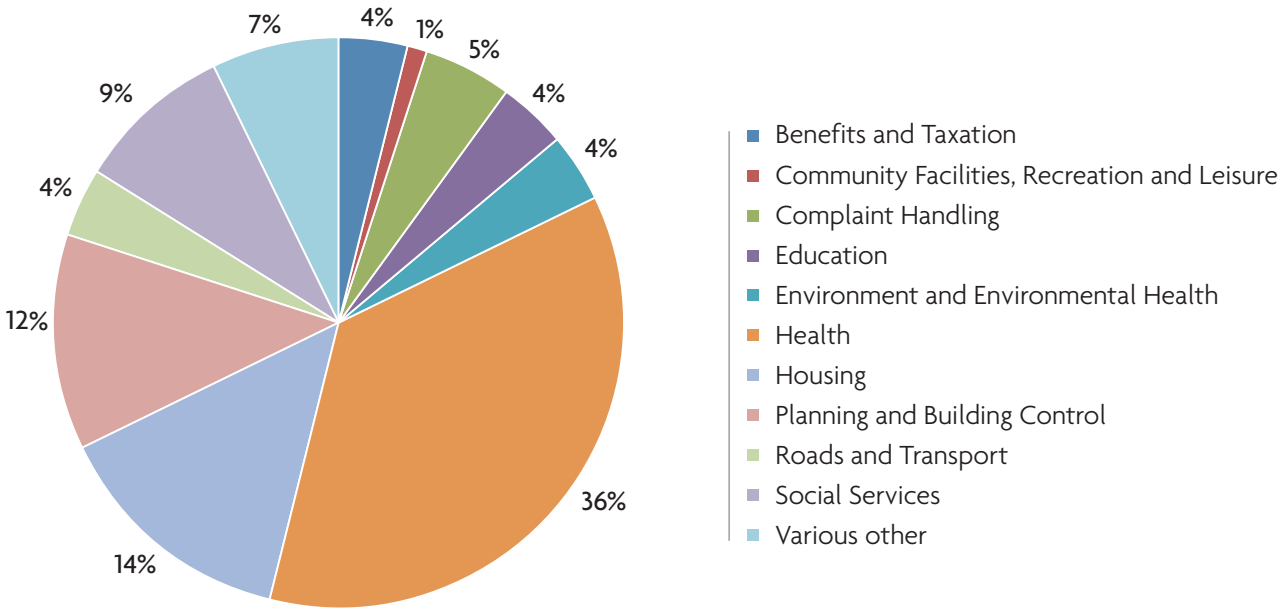
Complaints by public body sector



Complaints about public bodies by subject

As can be seen from the chart below, health complaints account for 36% of the caseload, compared with 37% in 2013/14. This very small decrease in ratio terms is due to an increase in other types of complaints received rather than a fall in the number of health complaints received (as confirmed by the details on the previous page). As has been the case in recent years, housing (14%) and planning (12%) are the service areas which account for the greatest number of complaints received after health complaints. In terms of the areas of growth however, most notable is that of social services, where comparing the number of social services complaints received in 2013/14 with 2012/13, there has been a 19% increase. This clearly is a matter of concern and suggests that service user discontent with social service provision is now beginning to manifest itself in a similar way to service users of health provision.

Complaints by subject 2013/14



[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 last year is given in the table below. Complaints included in the category 'Cases closed after initial consideration' include those received which:

- were outside of the Ombudsman's 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 2013/14 is set out at Annex B.)

Complaint about a Public Body	**2013/14**	**2012/13**
Closed after initial consideration	1,402	1,260
Complaint withdrawn	47	26
Complaint settled voluntarily (includes "quick fix" of 171 cases)	214	177
Investigation discontinued	18	21
Investigation: complaint not upheld	63	68
Investigation: complaint upheld in whole or in part	173	163
Investigation: complaint upheld in whole or in part – public interest report	9	10
Total Outcomes – Complaints	**1,926**	**1,725**

Decision times

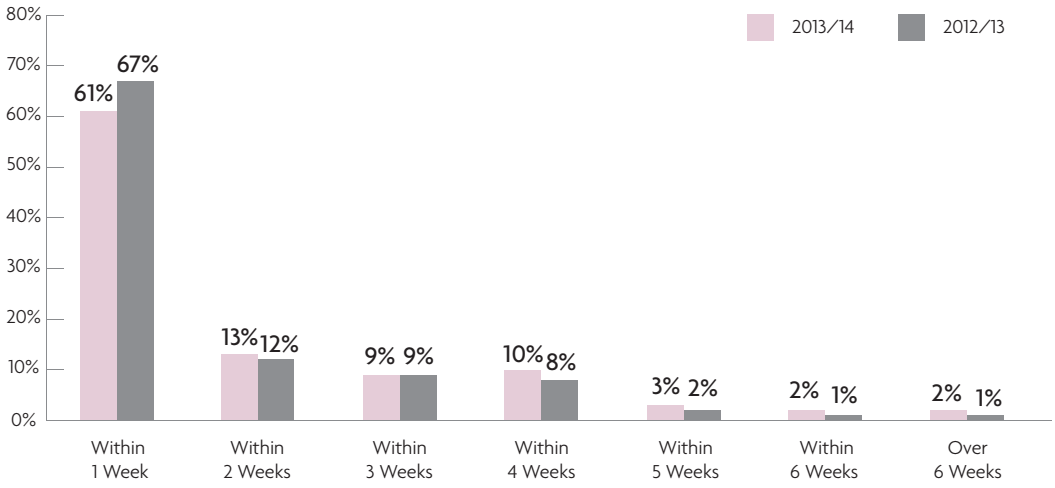
Below are two charts which report on decision times. These show how we have performed against the two key targets we have set ourselves, which are:

- at least 90% of all complainants to be informed within 4 weeks whether the Ombudsman will take up their complaint (from the date that sufficient information is received)
- to conclude all 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).

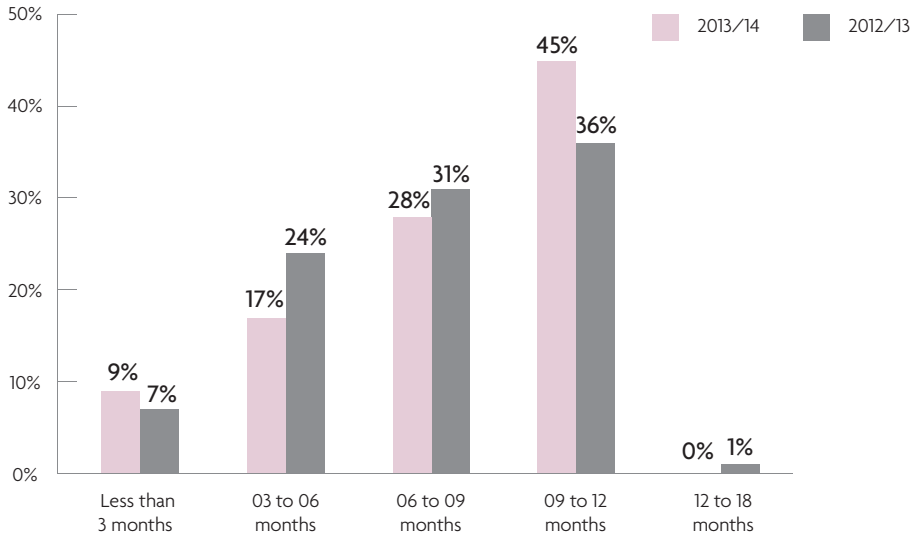
Particularly in view of the increase of enquiries and complaints to the office, it is very pleasing that we surpassed our first target and actually informed 93% of complainants within the 4 week timescale.

Performance with regard to the second target is also very satisfactory. The chart below shows that we achieved a 100% rate in completing investigations within 12 months. Nevertheless, it should be acknowledged that there is a 'rounding issue' at play here and that in fact one case did take longer than this. The relevant case was a complex one concerning continuing health care. The investigation necessitated detailed enquiries of the Welsh Government in relation to the approach taken by health boards when assessing continuing health care eligibility across Wales.

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) continues to provide 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 the Ombudsman. At this point of first contact, we will act in various ways, such as:

- advise people how to make a complaint to this office
- 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 the PSOW's jurisdiction, direct the enquirer to the appropriate organisation able to help them.

It is also important to note that, where appropriate, the CAT also seeks to resolve a problem at enquiry stage without taking the matter forward to the stage of a formal complaint.

We are pleased that despite the continued increase in enquiries to this office 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. There were 7,943 main line calls to the office during 2013/14, and it is an excellent performance that 99.8% of these were answered within this timescale.

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. The team endeavours to identify ways of addressing 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, we are pleased that we were able to achieve 171 'quick' fixes in 2013/14 compared to 150 in 2012/13. Summaries of the complaints that we are able to resolve in this way can be found in the Ombudsman's Casebook available on our website: www.ombudsman-wales.org.uk.

Joint investigations

Under the PSOW Act, the Public Services Ombudsman for Wales is able to co-operate with other Ombudsmen. It is the practice to draw attention in the PSOW's Annual Reports to any such joint investigations. However, no complaints received by the PSOW 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 228 new complaints, **down 22%** on 2012/13.
- We referred 6 investigation reports to either a standards committee or the Adjudication Panel for Wales, **down 70%** on 2012/13.
- We closed 229 cases, **down 38%** on 2012/13.
- We had no investigations older than 12 months open at 31 March 2014.

Complaints received

The table below gives a breakdown of the code of conduct complaints received by type of authority.

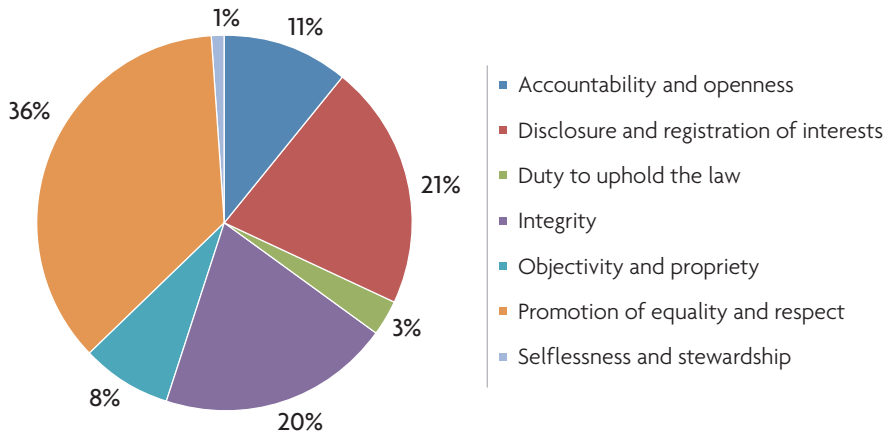
	2013/14	2012/13
Community Council	115	140
County/County Borough Council	111	150
Fire Authority	2	0
National Park	0	0
Police Authority	0	1
Total	**228**	**291**

It is particularly pleasing to see that the number of code of conduct complaints have continued to fall. The new local resolution arrangements introduced by local authorities over the past year or so is clearly having the desired effect with the decrease of 22% of complaints to this office compared with the previous year. It is now our practice under these new arrangements to refer 'low level' complaints made by one member against another, such as allegations of failures to show respect and consideration of others under paragraph 4(b) of the code, to authorities' monitoring officers to be dealt with locally.

We have also continued with the approach adopted last year of writing to the local Monitoring Officer when the Ombudsman is minded not to investigate a complaint, or, having commenced an investigation, is minded to close the case. This will arise when it is judged 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 should they decide that there has been a breach of the Code, then the investigation is transferred to them for local consideration. During the past year, 16 such complaints were referred to monitoring officers, of which 1 was called in for local investigation.

Nature of Code of Conduct complaints

As in previous years, the majority of complaints received during 2013/14 related to matters of 'equality and respect'. In 2013/14 this was 36% of the code of conduct complaints received compared to 35% in 2012/13. The next largest areas of complaint related to disclosure and registration of interests (21%), and integrity (20%).



Summary of Code of Conduct complaint outcomes

Of the Code of Conduct cases considered in 2013/14, 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).

Complaint about a public body	2013/14	2012/13
Closed after initial consideration	176	283
Complaint withdrawn	12	12
Investigation discontinued	8	18
Investigation completed: No evidence of breach	10	23
Investigation completed: No action necessary	17	15
Investigation completed: Refer to Standards Committee	5	15
Investigation completed: Refer to Adjudication Panel	1	5
Total Outcomes – Code of Conduct complaints	**229**	**371**

(A detailed breakdown of the outcome of Code of Conduct complaints investigated, by local authority, during 2013/14 is set out at Annex C.)

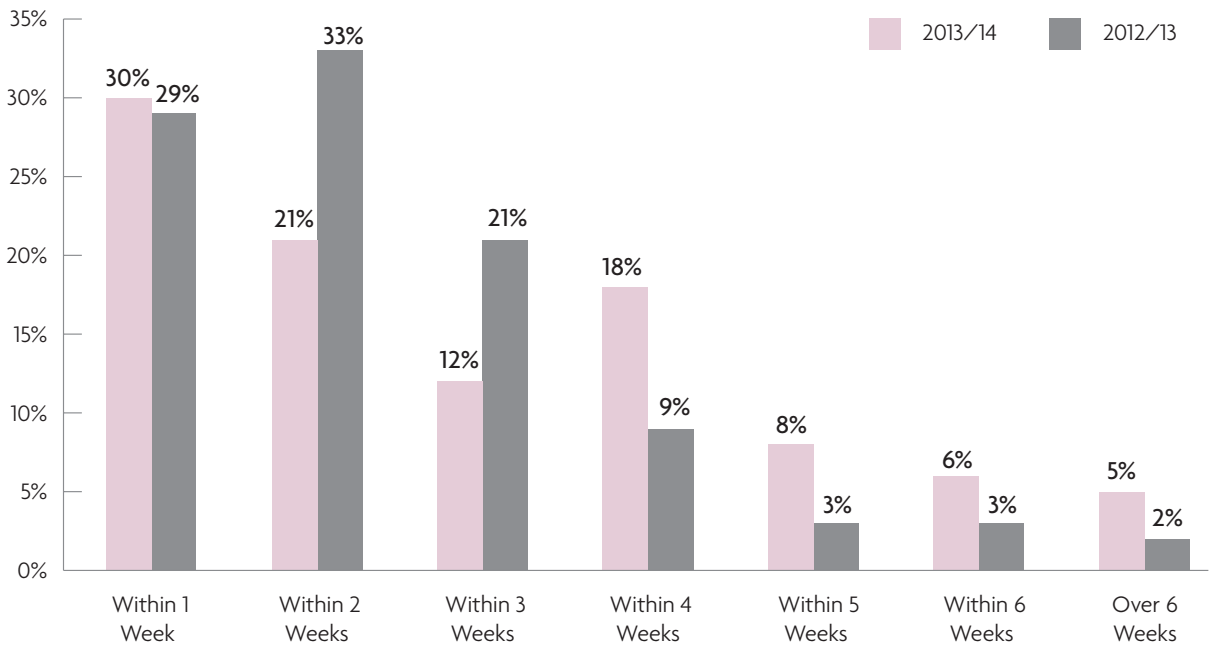
Not only have the number of code of conduct complaints to the office decreased over the past year, notable is the reduction in the number of cases referred to either an authority's standards committee or to the Adjudication Panel for Wales, which fell significantly from 20 in 2012/13 to 6 in 2013/14. This is partly attributable to the effects of the High Court judgement on the Calver case in 2012. The ruling on this case, concerning a member's freedom of expression attracting enhanced protection under the Human Rights legislation when comments made are political in nature, has had an impact on the application of paragraph 4b of the Code of Conduct relating to treating others with respect and consideration. Taking account of the ruling that politicians need to have 'thicker skins, the bar has now been raised on what the Ombudsman refers to a Committee or the Panel.

Decision times

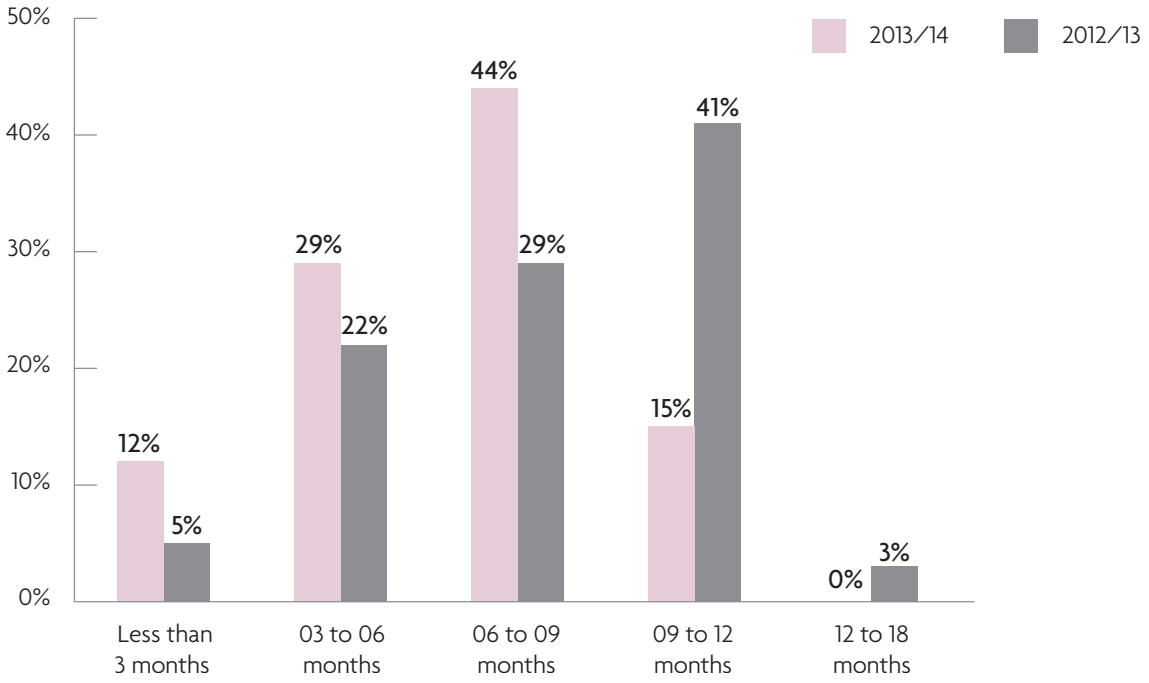
Below are the decision times for code of conduct complaints. The time targets set for code of conduct complaints are similar to those for complaints about public bodies, that is:

- at least 90% of all complainants to be informed within 4 weeks whether Ombudsman will take up their complaint (from the date that sufficient information is received)
- to conclude all cases within 12 months from the point that a decision is made to take up a complaint (that is, to commence investigation of a complaint).

Decision times for informing complainants we will take up their complaint



Decision times for concluding code of conduct investigations



In respect of the first target, we actually achieved this 81% of the time, and it is a little disappointing that we have not been able to achieve the 90% target in respect of code of conduct complaints and that we were unable to sustain our performance in 2012/13. This will be a matter that we will be looking to address in the year to come therefore.

With regard to the second target, and on a much more positive note, we are particularly pleased that we achieved a 100% success rate for completion of code of conduct investigations within 12 months. When looking back on previous Annual Reports it can be seen that our performance on code of conduct cases has been improving year on year. It is especially pleasing when comparing the position to three years ago when only 63% of code investigations were concluded in under 12 months. Against that position, the fact that over the past year 85% of investigations were completed in less than 9 months is even more gratifying.

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

The PSOW has previously made clear concerns about the levels of indemnity enjoyed by members who are accused of a breach and the need for this to be addressed. This is particularly of concern when considering the best use of public money, especially when all publicly funded organisations are working within a very difficult financial climate. 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. Following discussions with the WLGA a proposed ceiling of £20,000 was agreed. Good progress

has been made by local authorities in introducing such a cap over the past year or so. However, it is disappointing that a couple of councils who have an insurance arrangement in place for indemnity have stated that they are unable to fall in line due to insurance companies resisting such a ceiling.

Welsh Government Ministers had previously indicated that they may consider addressing this matter through legislation if wholesale voluntary agreement could not be secured. This is a matter which may therefore need to be re-raised in the forthcoming year.

As the third strategic aim of our Three Year Strategic Plan sets out (see Annex D), we place great importance on using the knowledge and learning gained from our work to improve public service delivery in Wales and to inform public policy. We have continued over the past year to do this through a number of key vehicles, some of which are provided for in the PSOW Act.

Public interest reports

During 2013/14 we issued nine public interest reports (summaries of these are at Annex A and their full text is available on the website at www.ombudsman-wales.org.uk). Being able to publish investigation reports (under section 16 of the PSOW Act) means that we are able to draw attention to lessons that can be learnt from our investigations; lessons that may apply to other similar public bodies. When appropriate, we also draw the attention of the Welsh Government to such reports so that it can also give consideration to any implications from a wider public policy perspective.

The Ombudsman's Casebook

We continue to publish the Ombudsman's Casebook, which many of the organisations in jurisdiction now see as a valuable learning tool. The Casebook gathers together summaries of all of our investigation reports regardless of whether they are issued under section 16 or section 21 of the PSOW Act – the latter being reports which are not formally published because the cases are not considered to be of public interest in themselves. Nevertheless, as a body of work, there are often lessons that can be learnt. The Casebook also includes summaries of the quick fixes achieved so that the learning from the cases that we resolve informally can also be shared.

Topics addressed in the four digests published during 2013/14 are set out below. The key issues identified where lessons could be learnt were as follows:

- the need for public service providers to properly take account of a specific need when providing a service (for example if someone has a disability or health condition)
- delays in providing a service, which can in and of themselves be examples of maladministration, and can sometimes compound a particular problem or be the cause of a complaint itself
- poor complaint handling, including shortcomings in the investigations where these had not been sufficiently robust and responses to complainants were found to be not sufficiently accurate, thorough or transparent.

The Code of Conduct Casebook

Due to the success of the Ombudsman's Casebook, we received requests from local authority monitoring officers for a similar publication in relation to the code of conduct investigations that we undertake. In response to this demand, therefore, we issued the first edition of the Code of Conduct Casebook in November 2013. The new Casebook includes summaries for all code of conduct

cases which have been taken into investigation. However, to ensure that information is put into the public domain at appropriate time, we will be not be publishing the summaries of any cases awaiting Standards Committee or Panel hearings until the outcomes of the relevant hearings are known; when these are available the Casebook will provide links to the appropriate decisions. Whereas The Ombudsman's Casebook is produced on a quarterly basis, the new Code of Conduct Casebook will be published twice per year.

Annual letters

We have continued with the practice of issuing Annual Letters to county/county borough councils and health boards, which are also published on our website. We 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. The Annual Letters are also used as the basis of discussions with the Chairs and Chief Executives of individual local health boards. Local authorities are also invited to seek a meeting to discuss their particular Annual Letter if they so wish.

Complaint handling by public service providers

There has also been a continued interest on progress on the adoption of the Model complaints policy and guidance issued to public service providers by Welsh Government. The fact that all but one of the county/county borough councils have now adopted, or are imminently about to adopt, the Model is very welcome. It is believed that the remaining council is also working towards its adoption. With regard to housing associations, although a good number have adopted the Model Policy, take up has been somewhat slower amongst this sector; the issue of how this might be progressed will be a matter for consideration in the forthcoming year.

Informing Public Policy

Another means of achieving our aim of contributing to public policy discussions is through engaging with Welsh Government consultations and Welsh Assembly Committee scrutiny activities. For example, using the evidence from our investigations we responded to consultations on the Continuing NHS Healthcare National Framework and the Government's proposals to reform the planning system in Wales. In addition, we appreciated the opportunity to contribute our views to the review of concerns and complaints handling within NHS Wales being undertaken by Mr Keith Evans at the request of the Welsh Government. We also gave evidence to a number of Assembly Committee meetings on issues such scrutiny of the Social Care and Wellbeing Bill and the inquiry into the work of Healthcare Inspectorate Wales. The opportunity to discuss the PSOW's Annual Report with the Communities, Equality and Local Government Committee and share the learning for public service providers emerging from our work was welcomed once again.

The Ombudsman

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

Governance arrangements

Advisory Panel

The Advisory Panel, established during 2011/12, continued to meet on a regular basis over the past year. The Panel was set up with the aim of enhancing openness and transparency of the 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.

At the end of 2013/14 a review of the effectiveness of the Panel was undertaken, which took into account the views of Members themselves. This proved to be a positive exercise with all involved satisfied that the Panel added the additional scrutiny and support sought by the Ombudsman.

The Membership during the year was as follows:

- Ceri Stradling (also Chair of the Audit & Risk Committee) – a former Senior Partner with the Wales Audit Office (until beginning March 2014)
- 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, and currently IPCC Commissioner for Wales
- John Williams – former Director of Social Services for Conwy County Borough Council.

My role on the Panel changed from the beginning of December upon being appointed Acting Ombudsman and, for the time being, I am no longer 'an Independent Member'. However, in view of the fact that my appointment as Acting Ombudsman is an interim measure, it was decided not to fill the temporary vacancy that has arisen.

Due to his appointment to bodies within the Ombudsman's jurisdiction, Ceri Stradling resigned from the Panel towards the end of the year. Consideration will now be given to filling the vacancy that has arisen. However, I wish to take this opportunity to record our thanks Mr Stradling for his considerable contribution as a member of the Advisory Panel, but particularly for his valuable and highly appreciated work as Chair of the Audit & Risk Committee.

Audit & Risk Committee

The use that the Ombudsman makes of the resources available to the office is subject to the scrutiny of the Wales Audit Office, which is responsible for auditing the Ombudsman's 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', the Audit & Risk Committee is charged with advising the Ombudsman in the discharge of the Accounting Officer duties. Again, with the impact of the interim arrangements with the change of Ombudsman, I stood down on a permanent basis as an independent member, but remain on the Committee as the Accounting Officer. John Williams, an existing Advisory Panel Member, kindly agreed to take my place as one of the independent Committee members. Furthermore, following Ceri Stradling's resignation, I was grateful to Bill Richardson, an existing member of the Committee, for agreeing to henceforth take the position of Chair of the Committee.

The Audit & Risk Committee considers matters including budget estimates, annual accounts, external and internal audit reports, and risk management issues. The Committee met four times during 2012/13 and it is pleasing that no substantive matters of concern were raised during the year. Deloitte continue to be the internal auditors and their programme of work is guided and overseen by the Audit & Risk Committee, where the good and constructive relationship developed in previous years continues.

Management Team

Whilst the Ombudsman is solely accountable for the decisions and operation of the office, the Management Team is a formal group that provides advice and support. It takes specific responsibility for advising 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

The past year was the second in relation to implementation of the Strategic Plan developed for 2012/13 to 2014/15 and many of the activities and achievements have been reflected in this Annual Report. The existing vision, values, purposes and strategic aims for the PSOW service can be found at Appendix D. A 'Year 3 Update' has been produced to take the office forward into the final year of the Strategic Plan as has an annual Business Plan for 2014/15, 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, the PSOW published a 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, the PSOW is required to report annually on relevant equality issues. This is done via Section 8 of this Annual Report.

7. Other Activities

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 the fact that utility services have now been provided by private entities for many years. Furthermore, if people have already complained directly to the service provider, then the service will signpost them to the relevant ombudsman or other complaint handling body.

The service is now well developed, but we proceed to build on the information and data we hold on advice and advocacy organisations, including giving summary details on our website of the type of service provided by these bodies.

During the past year, we continued with our promotional activity for the service. The quarterly radio campaign, which began in 2012/13, continued and this was supplemented by an advertisement campaign on buses throughout Wales during December 2013.

Complainant satisfaction research

Research via complainant satisfaction surveys has been an important means of understanding complainants' views of the service we provide. At the beginning of 2013/14 we began undertaking our complainant satisfaction survey and our equality monitoring work as one exercise. We will in 2014/15 begin analyses to see whether there are variations to satisfaction levels between various groups of people. If differences in satisfaction do emerge we will then work to understand why this might be and what we may be able to do to address the position.

However, for the time being, below is the feedback received in relation to customer satisfaction for our first contact service. The overall outcome of responses during 2013/14, 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 Public Services Ombudsman for Wales	83%
The service I have received has been helpful and sensitive	73%
Staff were able to understand my complaint / The person that dealt with my query knew enough to be able to answer my questions	75%
I was given a clear explanation of what would happen to my query/ complaint	82%
The service has provided what I expected of it	64%

As can be seen, overall there is a very good level of satisfaction. It is notable that with regard to the final question, the way in which service users respond to this question is often affected by a decision by the Ombudsman not to investigate their complaint, for example, because the person concerned has not yet complained to the relevant organisation or that the matter is outside of the Ombudsman's jurisdiction. Sometimes, people decline to answer this question, saying that they are going to wait for the Ombudsman's decision on their complaint.

Information and Communication Technology (ICT)

Ensuring that we have appropriate up to date hardware and software has been key in enabling us to deal with the ever increasing complaints caseload being received. Focus over the past year has been to replace desk top PCs, introduce Wifi installation and to increase bandwidth, all of which are aimed at enabling staff to more work more efficiently.

Communication

Websites: Our work in 2013/14 focussed on developing mobile versions of both the Ombudsman's website and the Complaints Wales websites. This work was consistent with our aim to make our service accessible to everyone. Already aware that online was increasingly becoming the chosen method for people to make their complaint to the Ombudsman, our analysis of website users indicated that more and more were accessing the service via mobile and tablet devices. Apart from wanting a visually pleasing solution, it was important for us that the user experience in making a complaint about a public service via a mobile device should be equally as easy as doing so on a desk top computer. The new mobile versions were launched in January 2014 and to date feedback received has been very positive.

Traditional Media: Good television and radio coverage (both English and Welsh language) continues, with focus again being on the public interest reports issued. A good level of coverage in the press has also continued with 179 articles mentioning the Public Services Ombudsman for Wales during 2013/14, which is a similar level to the previous year.

Outreach: We have also continued with our practice of meeting with and addressing various voluntary organisations. For example, during the past year we spoke at a Swansea Bay BME Forum, Citizens Advice Bureau meetings and an Age Cymru safeguarding conference. We also spoke at a number of events held by the professional and representative bodies of those delivering public services (for example, medical professionals; housing associations). In addition to this we held a seminar for the complaints officers of local health boards and trusts. This enabled us to discuss with those at the coal face of complaint handling the issues they faced in dealing with complaints in their organisations. It was an opportunity to air the problems they encountered and what might be done to improve the way complaints are dealt with and investigated. We also explored how health boards and trusts might themselves be able to learn from the lessons for the complaints they handle internally themselves.

Human resources

The position regarding the change in Ombudsman has already been discussed in this report. However, another key change took place during the year in relation to the senior management of the office. The Director of Investigations and Legal Adviser had at the end of 2012/13 announced her intention to retire in December 2013. As a result, a review of the management structure of the office was undertaken and some minor changes were introduced. A post of Chief Operating Officer & Director of Investigations was introduced, a recruitment exercise was undertaken, and the successful applicant commenced in post in March 2014. The Legal Adviser role has now been taken on by one of the office's existing Investigation Managers. However, in order to facilitate a smooth transition over the period of the Acting Ombudsman's tenure of office, the Director of Investigations and Legal Adviser agreed to continue to work at the office on a part time basis until such time as a permanent new Ombudsman took up post.

We also towards the end of the year recruited to the additional investigator post created as a result of the social services changes to be introduced during 2014/15 and the expected increase in complaints to this office. This has allowed for a suitable period of training prior to the relevant legislative changes being introduced. We also recruited to a number of posts which had been held vacant from 2012/13.

The organisational structure as at 31 March 2014 can be found on page 31.

The PSOW and the Ombudsman World

In many ways the role of the Ombudsman is unique. Although no one Ombudsman scheme is exactly like another, the work of the Ombudsman Association (OA) is considered to be important as a means of sharing best practice and to learn from each other. This is particularly valuable in view of the fact that Ombudsman schemes need to be objective and maintain an appropriate distance from the bodies in jurisdiction. We have continued to participate in OA activities, including participating in a number of the OA Interest Groups.

It was reported last year that Wales had been asked to host the next European Regional Ombudsmen conference. We have during the year been working with the European Ombudsman and her staff in organising the event, which will take place between in June 2014. We are particularly grateful to Mrs Rosemary Butler, the Presiding Officer, for agreeing to host a welcome reception at the Senedd for our European colleagues on the evening of their arrival for the conference.

The PSOW was also very pleased to be able to welcome delegations from other parts of the world to the office. In April 2013, we were delighted to discuss the work of our office with colleagues from Uganda, Gambia and Nigeria. Then, in July we hosted a 26 strong delegation from China. We again had an opportunity to discuss the work of our office, including how we take human rights considerations into account whilst undertaking our investigation work.

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 our website: www.ombudsman-wales.org.uk.

The table below reports on the number of complaints received during 2013/14 and their outcomes, together with a comparison of the position in 2012/13.

Details of the 'complaints about us' received	**2013/14**	**2012/13**
Complaints brought forward from previous year	2	2
Not upheld	13	32
Upheld in whole or in part	7	12
Referred back to Investigation Manager or Review Manager (investigation decision related)	17	10
Complaint withdrawn or insufficient information	7	3
Still open at 31 March	3	2
Total received	**45**	**59**
Total closed during year	**44**	**59**

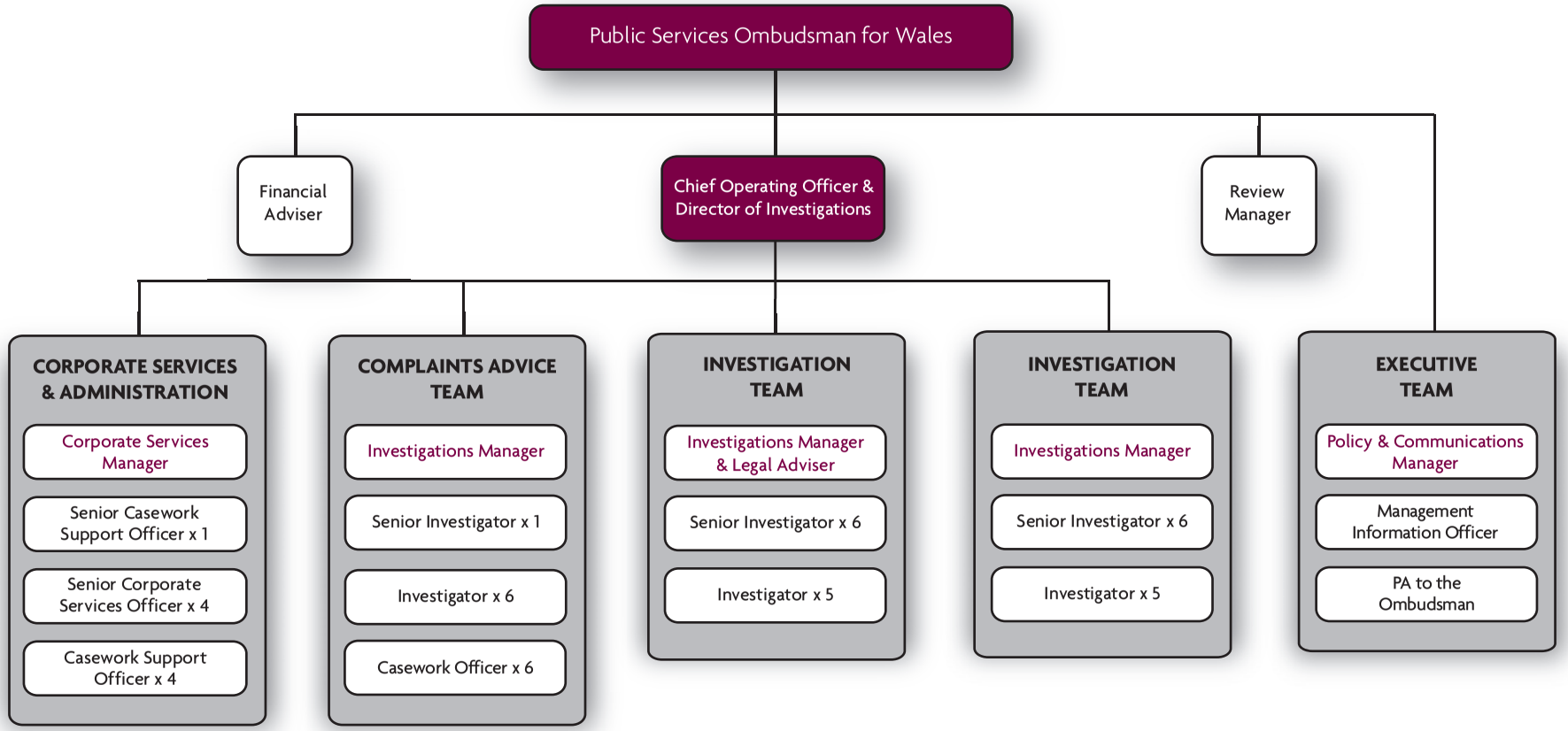
The nature of the complaints that were upheld/partly upheld were:

Incorrect information provided	1
Failure to return call within reasonable timeframe	1
Undue delay in response	2
Failure to act upon request for e-mail contact only	1
Correspondence sent to incorrect address	2
Total	**7**

As a consequence of the above, the following action was undertaken:

- an apology was issued to the complainant in all 7 cases
- the relevant managers were made aware of the upheld complaints relevant to their team for future training considerations and monitoring
- where appropriate, action in accordance with PSOW HR policies was undertaken
- staff training for all staff was undertaken with regard to postal and electronic correspondence information security
- the case management database was enhanced to reduce the risk of missing requests for email contact only from complainants.

Organisational Chart (position as at 31 March 2014)



8. Equality Issues

A commitment to treating people fairly is central to the role of an ombudsman. The Public Services Ombudsman for Wales is committed to providing equal opportunities for staff and in the service provided 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. Staff are expected to share the Ombudsman's total opposition to unlawful and unfair discrimination and the 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, the Ombudsman has a duty to publish a Strategic Equality Plan and equality objectives. The first such Plan, which contains the Ombudsman's 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 the website: see www.ombudsman-wales.org.uk). Also under the specific duties, the Ombudsman is required to produce an annual report in respect of equality matters. As articulated in the 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 the annual report on equality matters, which is 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 homes.

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.

At the end of 2013/14 mobile websites were introduced and it is the intention to introduce a version of BrowseAloud (or similar application) specifically designed for tablets and smartphones in the forthcoming year.

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 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 was published in the Strategic Equality Plan.

However, as described in previous sections of this Annual Report, we have during 2013/14 revised our equality monitoring process and methods. The outcome of the monitoring in respect of the protected characteristic groups (as defined in the Equality Act) is set out below.

In view of the nature of the work of this office, we would expect the composition of people who complain to this office to, at the very least, mirror the national demographic position; in fact, we would expect the proportion of complainants from groups who could be considered to be at disadvantage or vulnerable to exceed the national picture. In respect of each of the questions we asked, those who completed the form were given the opportunity to responsd 'Prefer not to say'. Nevertheless, from the results below, the PSOW is relatively satisfied that in making comparisons with official data available (e.g. the Census 2011) the composition of our service users meets or exceeds national demographics in the way we would expect. The slight exception relates to people from minority ethnic backgrounds, who comprise 3% of those who responded to our monitoring survey, whilst, according to the Census 2011, 4% of people in Wales identify themselves as having a minority ethnic background.

We take the results from our equality monitoring into account when developing our outreach programmes. We began work in raising awareness of the PSOW service among people from minority ethnic groups during 2013/14; this will be continued into 2014/15.

Protected characteristic group	Percentage Outcome
Age:	
Under 25	4%
25-34	14%
35-44	14%
45-54	21%
55-64	19%
65-74	15%
75 or over	6%
Prefer not to say/No response	7%

Protected characteristic group	Percentage Outcome
Disability	
Yes	26%
No	60%
Prefer not to say/No response	14%
Health problem or disability limiting day-to-day activities?	
Yes, limited a lot	26%
Yes, limited a little	17%
No	43%
Prefer not to say/No response	14%
Gender reassignment	
Yes	0.5%
No	46.0%
Prefer not to say/No response	53.5%
Religion or belief	
No religion	34%
Christian (all denominations)	50%
Other religions	6%
Prefer not to say/No response	10%
Married or same-sex civil partnership	
Yes	46%
No	41%
Prefer not to say/No response	13%
Race/Ethnicity	
White	89%
Other ethnic background	3%
Prefer not to say/No response	8%
Sex	
Male	46%
Female	46%
Prefer not to say/ No response	8%
Sexual orientation	
Heterosexual or straight	83%
Gay or Lesbian	2%
Bisexual	1%
Other	0%
Prefer not to say/No response	14%

Our Casework

Our commitment and contribution to equality matters also manifests itself in our complaint handling work. Indeed, the edition of the Ombudsman's Casebook published in October 2013 gave particular attention to the issue of failures by public bodies to take account of the specific needs of service users when providing a service and gave specific examples of these. It was emphasised that public service providers should be mindful of their obligations under Equality legislation. As pointed out in the Casebook, whilst it is not for the Ombudsman to decide whether a public service provider is in breach of such legislation, it is possible that the failure to take account of any such legal obligations, or to follow policies and procedures designed to implement these obligations, will be maladministration.

Training

PSOW 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, in the past year, two members of staff commenced training on how to communicate via British Sign Language. Secondly, so that we have the knowledge to be able to identify during our investigations any failings by public service providers in respect of their 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, Children's, and Welsh Language Commissioners in relation to co-operation, joint working and the exchange of information.

Equality Impact Assessments

As part of the work in developing the Strategic Equality Plan, we developed an equality impact assessment toolkit. Equality Impact Assessments are now embedded in our practices when reviewing existing, or developing new, policies and procedures.

Staff Equality Data Gathering/Monitoring

Our staff have been asked to complete and return a monitoring form seeking information in respect of each of the protected characteristics. We also now gather such information during our recruitment exercises. That disclosure is, of course, on a voluntary basis. The data held at 31 March 2014 is set out below.

Age	The composition of staff ages is as follows: 21 to 30: 17% 31 to 40: 29% 41 to 50: 31% 51 to 65: 23%
Disability	84% of staff said there were not disabled, no member of staff said that they were a disabled person (16% 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, 81% said their day to day activities were not limited (16% preferred not to say)
Nationality	In describing their nationality, 50% said they were Welsh; 26% said British, 10% said they were English, 2% said 'Other' (12% preferred not to say)
Ethnic group	The ethnicity of staff is: 79% White (Welsh, English, Scottish, Northern Irish, British); 2% White/Irish 3% Black (African, Caribbean, or Black British/Caribbean 2% Asian or Arian British/Bangladeshi (14% preferred not to say)
Language	When asked about the main language of their household, 76% of staff said this was English; 10% said Welsh, and 2% said 'Other'
Religion or Belief	Responses to the question asking staff about their religion were as follows: No religion: 38%; Christian 38%; Muslim 2%; Other:1% (21% preferred not to say)
Marriage/ Civil Partnership	When asked if they were married or in a same sex civil partnership, 49% of staff replied 'Yes'; whilst 33% said 'No' (18% preferred not to say)
Sexual Orientation	Responding on this, 77% said that they were Heterosexual or Straight, 2% said Gay or Lesbian (21% preferred not to say)

Under the specific duties we are required to set an equality objective for gender and pay; if we do not do so, we must explain why. The 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. The position is kept under continual review and the equality objectives will be revised if necessary. However, as can be seen from the table below, the position currently remains satisfactory.

Pay and Gender – data as of 31/03/2014

Pay (FTE)	Male	Female
Up to £20,000	3	14
£20,001 to £30,000	1	2
£30,001 to £40,000	5	11
£40,001 to £50,000	6	10
£50,001 to £60,000	1	2
£60,001 +	1	2
Subtotal	**17**	**41**
Total	**58**	

In relation to the working patterns of the above, all staff work on a full time basis with permanent contracts, with the exception of the following;

- eight members of staff work part time (seven female, one male).
- four members of staff are employed on a fixed term contract (two female, two male).

Recruitment

During the year we have had one member of staff leave. Six new employees were recruited, five of these were to fill vacant posts, the other to appoint to the newly created investigation officer post (previously discussed in this Annual Report). Due to the low numbers involved, the equality data for the individuals concerned has been reported as part of the all staff information above; it is not considered appropriate to report separate equality information relating to these individuals due to the risk of identification.

Equality data gathered from the three recruitment exercises relating to the above new six employees results in the following:

		COO/ DOI	IO	CAT CO/ CWSO	Total
Number of applications		74	19	34	127
Age	Did not say	4%	11%	9%	6%
	under 25	0%	0%	32%	9%
	25-34	3%	26%	35%	15%
	35-44	18%	32%	15%	19%
	45-54	59%	32%	10%	42%
	55-64	16%	11%	0%	11%
Gender	Did not say	3%	5%	3%	3%
	Male	47%	42%	47%	46%
	Female	50%	53%	50%	50%
Nationality	Did not say	3%	5%	3%	3%
	Welsh	50%	95%	65%	61%
	English	8%	0%	12%	8%
	Scottish	3%	0%	3%	2%
	Northern Irish	3%	0%	0%	2%
	British	31%	0%	15%	22%
	Irish	1%	0%	3%	2%
	Welsh/German	1%	0%	0%	1%
Ethnic Group	Did not Say	3%	5%	9%	5%
	White (Welsh/Scottish/ English/NI/British)	91%	95%	79%	88%
	White (Irish)	5%	0%	3%	4%
	White (Gypsy/Irish traveller)	0%	0%	0%	0%
	White (Other)	1%	0%	0%	1%
	Asian/Asian British	0%	0%	6%	2%
	Black, African, Caribbean or Black British	0%	0%	3%	1%
	Mixed or multiple ethnic group	0%	0%	0%	0%
	Other ethnic Group	0%	0%	0%	0%
Language	Did not say	5%	16%	3%	6%
	English	85%	16%	97%	78%
	Welsh	5%	63%	0%	13%
	Bilingual (Welsh/English)	4%	5%	0%	3%
	Other	0%	0%	0%	0%

		COO/ DOI	IO	CAT CO/ CWSO	Total
Number of applications		74	19	34	127
Disability	Did not say	4%	5%	6%	5%
	Yes	0%	5%	0%	1%
	No	96%	89%	94%	94%
Limited Activities	Did not say	8%	5%	6%	7%
	Yes, limited a little	0%	0%	0%	0%
	Yes, limited a lot	0%	5%	0%	1%
	No	92%	89%	94%	92%
Religion	Did not say	7%	21%	15%	11%
	None	28%	32%	59%	37%
	Christian	65%	47%	25%	52%
	Buddjist	0%	0%	0%	0%
	Hindu	0%	0%	0%	0%
	Jewish	0%	0%	0%	0%
	Muslim	0%	0%	0%	0%
	Sikh	0%	0%	0%	0%
	Other	0%	0%	0%	0%
Married or civil partnership	Did not say	5%	5%	9%	6%
	Yes	70%	26%	15%	49%
	No	24%	68%	76%	45%
Sexuality	Did not say	7%	16%	21%	12%
	Heterosexual	88%	84%	74%	83%
	Gay or Lesbian	5%	0%	6%	5%
	Bisexual	0%	0%	0%	0%
	Other	0%	0%	0%	0%

Key to abbreviations:

- **COO/DOI** – Chief Operating Officer/Director of Investigation
- **IO** – Investigation Officer (it should be noted that fluency in the Welsh language was an essential criterion for this post; this therefore has an impact on the language category data for this post)
- **CAT CO/CWSO** – Complaints Advice Team Casework Officer or Casework Support Officer.

Staff Training

The majority of staff training is based upon job roles or applicable for all staff to attend. All individual staff requests for training over the past year were approved, and as such there are no equality data differences between approved and non-approved training requests.

Disciplinary/Grievance

Due to the small numbers of staff working in the office, and the small number of instances of disciplinary/grievance matters, it is not considered appropriate to report on equality data for this category due to the risk of identification of staff involved. However, we are able to state that we are satisfied that there are no identifiable issues of concern in this area.

Procurement

Our procurement policy 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

HEALTH

Cardiff and Vale UHB – Clinical treatment in hospital
Case reference 201204130 – Report issued February 2014

Mrs T complained about the treatment her husband, Mr T, received in hospital. She complained that he received excess intravenous fluids and that this fluid overload caused subsequent health problems, including multiple strokes, from which he sadly died in May 2011. Mrs T also complained that errors were made in her husband's medication when admitted to hospital, that the diagnosis of his stroke was delayed and that had he received appropriate and timelier treatment, he may have survived.

The Ombudsman found that the instance of fluid overload was not clinically significant in terms of the sad outcome. However, the Ombudsman upheld Mrs T's complaint, finding that the Health Board had failed to act in accordance with national guidelines for the treatment of stroke. The Ombudsman concluded that errors were made with Mr T's regular medication and that opportunities to diagnose Mr T's stroke and to implement treatment which may have increased his chances of survival were missed.

The Ombudsman recommended that the Health Board should:

1. issue to Mrs T and her family a comprehensive apology for the failings identified in this report;
2. review its arrangements in respect of post-admission medication reconciliation and ensure that a systematic medicine reconciliation programme is in place;
3. ensure that staff training in respect of recognising acute stroke is up to date, with particular reference to the 2012 Stroke Guidelines issued by the Royal College of Physicians;
4. ensure that use of the Rosier score system (or a similarly recognised tool), in order to identify patients who are likely to have had an acute stroke, is implemented;
5. with particular reference to the current Stroke Guidelines and NICE guidance, review its arrangements for the identification and treatment of acute stroke and consider including the following measures:
   (a) all patients who may have had an acute stroke (i.e. have been assessed as having a positive Rosier score) should be immediately assessed by a physician trained in stroke medicine to determine whether thrombolysis is suitable
   (b) suitable patients should have immediate CT scanning and, in all cases, within one hour
   (c) all patients who may have had an acute stroke should be admitted immediately to a specialist acute stroke unit
   (d) all patients who may have had an acute stroke should have a swallowing screening test, using a validated tool, by a trained professional within four hours;

6. review the findings set out in its various complaint responses to Mrs T and to this office and take action to ensure that its own complaints investigations are in accordance with the Putting Things Right scheme, are sufficiently robust, demonstrably independent and, where appropriate, critical of identifiably poor care, which should include the introduction of a quality assurance audit of a sample of its completed complaint investigations;
7. issue to Mrs T a cheque in the sum of £5000 in respect of the time and trouble to which she has been put in pursuing this complaint and in recognition of the additional distress caused to her and her family as a result of the uncertainty with which they now live over whether Mr T might have survived the initial stroke.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201204681 – Report issued December 2013

Mrs W complained about the care provided by Aneurin Bevan Health Board to her late husband (Mr W) when he was a patient at Nevill Hall Hospital in September and October 2011. Mr W was 80 years old when he died in hospital on 7 October 2011. Mrs W said that Mr W was deaf, but despite advising staff of this, it was not noted on his records. Mrs W said she believed that her husband was not treated in his best interests and that his care was compromised because staff did not consider his deafness. Mrs W said that she and her husband were not told about a cancer diagnosis by the Hospital. She also said that she was dissatisfied with the way that the Health Board communicated with her and her family both during the time Mr W was a patient and when the Health Board was considering the complaint she made about his care.

The investigation found that, as required by the Equality Act 2010, the Health Board failed to make reasonable adjustments to accommodate Mr W's deafness. The investigation also found that the Health Board failed to:

- record a significant clinical discussion with Mr W about scan results
- complete and record appropriate assessments relating to the risk of falling and the use of bed rails
- consult Mr W and record his consent for the insertion of a catheter
- follow national and local guidance on effective discharge planning
- keep appropriate records related to the discharge process
- follow relevant guidance on record-keeping.

The Ombudsman upheld the complaint and the Health Board agreed to:

a) give Mrs W an unequivocal written apology for failures identified by this report and make a payment of £500 to reflect the time and trouble taken in pursuing her complaint with the Health Board and this office;

b) formally instruct the nursing and clinical staff involved in Mr W's case that they must assess patients properly on admission and ensure that all relevant records of such assessments (for example, the Patient Care Record) are completed fully;

c) formally instruct the nursing and clinical staff involved in Mr W's case to follow the relevant record keeping guidance;

d) formally instruct the clinical staff involved in Mr W's case to ensure that significant clinical discussions with patients (such as the results of a scan) are recorded properly;

e) formally instruct the nursing staff involved in Mr W's case to ensure that all appropriate risk assessments are completed and properly recorded;

f) formally instruct the nursing and clinical staff involved in Mr W's case to follow the relevant discharge planning guidance;

g) share this report with all staff involved in Mr W's care so that the lessons that should be learned from the report can be understood;

h) ensure that this report is discussed at a meeting of each Directorate that cared for Mr W so that the lessons of the report are disseminated;

i) ensure that this report is discussed at a meeting of the working group responsible for the Health Board's "Dignified Care?" action plan.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case reference 201202432 – Report issued October 2013

Ms D complained that midwives at the University Hospital of Wales (UHW) wrongly informed her that her pregnancy dating scan revealed that she had suffered a 'silent' miscarriage. This error was detected only because Ms D elected to undergo uterine evacuation at a different hospital. There, a more thorough type of scan (a trans-vaginal [tv] scan) was performed which detected a healthy, viable foetus.

The Ombudsman upheld Ms D's complaint and found that the Health Board had failed to implement guidelines issued by the Royal College of Obstetricians & Gynaecologists (RCOG) that were designed to prevent the misdiagnosis of early pregnancy loss. These guidelines require midwives to conduct a TV scan in all such cases. The Ombudsman also found that the initial dating scan had been incompetently conducted and that midwives failed to take account of Ms D's relevant medical history. The Ombudsman recommended that:

a) the Health Board provides Ms D with a written apology and, in recognition of the inconvenience and expense incurred in obtaining alternative antenatal care, makes a payment to Ms D in the sum of £1,500;

b) further to the Health Board agreeing to take immediate steps to implement RCOG guidance in respect of the diagnosis of early pregnancy loss and to promptly notify all relevant clinicians within the Directorate that it has done so, it provides documentary evidence of how this process was accomplished;

c) the Health Board provides evidence that it has reviewed / assessed the competence of its midwife sonographers in respect of the diagnosis of silent miscarriage;

d) the Health Board shares with the Ombudsman the outcome of its complaint investigation review of this case (its Root Cause Analysis).

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case reference 201201954 – Report issued October 2013

This complaint is about the shortcomings in the care and treatment provided to Mr X at Glan Clwyd Hospital. In November 2000 Mr X had his first episode of bleeding from enlarged blood vessels in the gullet. This is a life-threatening complication of cirrhosis, a condition in which healthy liver tissue is gradually replaced with non-functioning scar tissue. The vessels were tied to prevent further bleeding. Several tests were carried out over the next few months. They showed clearly that Mr X had cirrhosis. Despite this, he was not informed of the diagnosis. Nor was he given necessary lifestyle advice. In September 2001 the hospital apparently made him an outpatient follow-up appointment, but Mr X was not told about this. This meant that Mr X was without any medical supervision for several years, with no information about his condition. As it happens, that probably made little difference to how his condition developed.

Mr X had further bleeding in August 2008. Again this was treated successfully, although for a while he was very unwell. This time Mr X received medication and some, but not all, of the necessary lifestyle advice. The Health Board also began investigating the cause of Mr X's cirrhosis, but stopped before finding it. Not until he requested, and received, a second opinion was Mr X told that he had been born with cirrhosis.

In 2010 Mr X returned to hospital several times in quick succession. He looked very unwell. Blood tests showed that his liver was failing. Despite this, the hospital sent him away, only finally admitting him three days after his appearance. By then Mr X was in liver failure and had a serious infection. Mr X rapidly deteriorated and he sadly died, aged 30, seven weeks later.

Had he been treated three days earlier, Mr X should have recovered from the infection and had a chance of receiving a liver transplant. This opportunity to survive and flourish was denied to him. The Ombudsman upheld the complaints that were made. The Health Board subsequently agreed to the Ombudsman's recommendations that it write to the family to acknowledge the failings and provide financial redress to Mr X's family; £5,000 in respect of the failings identified in Mr X's care and treatment

plus a further £500 for the poor complaint handling. The Health Board also agreed to review the care pathway and its appointments system. The Consultant in charge of Mr X's care also agreed to consider the issues raised in the investigation and learn from these.

Hywel Dda Health Board – Clinical treatment outside hospital
Case reference 201202535 – Report issued August 2013

Mr R complained about the treatment of his late wife (Mrs R) by a GP she saw as part of the Out of Hours GP service (under the governance of the Health Board). After telephoning the service Mrs R was directed to see the GP at the designated Out of Hours centre (based at a major hospital). She suffered from lymphoedema to her left arm following cancer treatment and complained about feeling unwell with a developing blister rash on her left arm. The GP diagnosed shingles, giving her a prescription of a common antiviral drug. The following morning Mrs R collapsed at home and was admitted to A&E at the same hospital; she died later that day from complete organ failure as a result of sepsis. Mr R complained that the GP had failed to examine his wife properly, or to diagnose her correctly. He also complained about how the Health Board had handled his complaint.

The investigation found that there was no record of the GP performing a number of basic assessments including temperature, pulse, and blood pressure. The Ombudsman's clinical advisers also found that the GP had failed to have proper regard to Mrs R's pre existing lymphoedema.

Whilst Mrs R's presentation might have suggested shingles, the GP ought to have also ruled out the blisters as a symptom of sepsis given it was well known that lymphoedema had a propensity to develop infection, which could lead to sepsis. An evident failure to consider this was unreasonable.

Had it been considered, Mrs R could have been given antibiotics, or admitted to hospital that day – the GP ought to have adopted a risk-averse approach. This might have affected the outcome given that prompt intervention in suspected sepsis is critical to survival prospects.

The Ombudsman also found maladministration in the Health Board's complaint handling: ranging from delays, fundamental errors in letters and no acknowledgement or response to a relevant third party. In recognition of the seriousness of the issues, the following recommendations were made, all of which the Health Board accepted:

- written apologies to Mr R and to a relevant third party;
- redress of £4,000 to Mr R for the failures identified in the care of Mrs R and £500 for the complaint handling failures;
- the Lead Clinical Director should undertake a sample review of the GP's Out of Hours clinical consultation records (minimum 6 sessions) and that all GPs delivering Out of Hours services should be reminded of the importance of performing full assessments/ examinations of patients and of recording those; and that

- the Health Board should ensure it had robust measures in place to secure timely and good quality responses to complaints.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case reference 201200939 – Report issued July 2013

Mrs D complained about the care and treatment her mother, the late Mrs M, received when she was admitted to the Accident and Emergency Department at the Princess of Wales Hospital on July 2010. Mrs D said that the triage nurse had not administered the treatment that her mother's condition required. There were also concerns about her subsequent treatment and in particular how discussions about the requirement to resuscitate, should that prove necessary, were managed. Mrs D held the view that her mother was initially being allowed to die without appropriate medical intervention and that the lack of intervention had led to her death some days later.

The Ombudsman's clinical advisers were highly critical of the failure of staff to deal with Mrs M's condition on arrival appropriately. They could not find any evidence of appropriate intervention as required by procedures such as nursing staff calling a doctor. There were also delays in cannulating Mrs M and in administering medication appropriate to her health needs. They could not however point to evidence that the failures in early intervention had contributed to Mrs M's death.

The Ombudsman recommended that the Board should apologise to the family for the failings in the report, make a payment of £1,000 and review its procedures and the professional competence and training of the nursing staff involved in the admission of Mrs M. The Board accepted the recommendations.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case reference 201201275 – Report issued July 2013

Mr and Mrs Q complained about the care and treatment Mr Q had received as a patient at Glan Clwyd Hospital and Wrexham Maelor Hospital.

Having reviewed the evidence, the Ombudsman found that during Mr Q's admission to Glan Clwyd Hospital on 17 and 18 May 2011 the "In-Patient Medication Administration Record" had not been appropriately completed. As a result, it was unclear whether Mr Q had received any of his Parkinson's disease medication.

With respect to Mr Q's discharge from Wrexham Maelor Hospital on 22 May 2011, the Ombudsman found that the medical records for this period failed to fully reflect Mr Q's anxious and difficult behaviour, the actions taken by staff to reassure him, any medical reviews undertaken by doctors or need to call a security officer. As a result Mr Q was discharged from hospital without assessment, placing Mr and Mrs Q in a vulnerable position.

The Ombudsman recommended that the UHB apologise to Mr and Mrs Q for the failings identified in the report and pay them £750 in recognition of the service failure and the time and trouble in bringing their complaint to this office. The Ombudsman also recommended that the UHB:

- review Mr Q's "In-patients Medication Administration Record" for the period 17-18 May 2011, and where appropriate instigate the UHB's "Medicines Management Assessment Workbook and Competencies" document, in accordance with the UHB's procedure;
- review Mr Q's medical records for the period 19-22 May 2011 and where appropriate take action in accordance with the UHB's procedures;
- remind the relevant staff that in the event that a security officer is called an "Incident Recording Form" should be completed;
- bring the updated discharge protocol to the attention of the relevant staff and introduce discharge drop in sessions at the Second Hospital;
- produce a training plan ensuring that within 12 months all relevant staff at the Hospital receives training on record keeping.

Cardiff and Vale University Health Board – Continuing care Case reference 201101810 – Report issued April 2013

Solicitors complained on Mrs S's behalf that the Cardiff and Vale University Health Board had failed to administer matters in relation to her mother Mrs W's claim for continuing health care correctly.

Mrs W had been in a nursing home since 2002 and was receiving funding for the nursing element of her costs. Her home had been sold to pay for the remaining element of her care home fees. The Solicitors submitted evidence which they said showed that there had been delay and error in dealing with Mrs W's assessments for continuing health care and that the Independent Review Panel had also not dealt with matters properly. They alleged that this situation had led to injustice to Mrs W through delay and financial loss.

The Ombudsman found that there had been significant maladministration in two assessments carried out by the Board and that there were failings on the part of the Independent Review Panel, although the second assessment had in fact found Mrs W to be eligible for continuing health care.

The Ombudsman recommended that his report should be brought to the attention of the Independent Review Panel, to consider what further training it needed and that a retrospective assessment of Mrs W's needs should be carried out under the supervision of an independent person nominated by the Welsh Government. He also recommended that the Board should revise its procedures and conduct a retrospective review of all cases that had been handled in the same way as Mrs W's in terms of the start date for funding. Mrs S was to receive a payment of £750 and an apology for the failings.

The Ombudsman highlighted to the Welsh Government that there was a lack of appropriate guidance on these matters and it was agreed that such guidance would be introduced. The Ombudsman decided that the case raised matters of public interest.

HOUSING

Tai Ceredigion Cyf – Applications. allocations. transfer and exchanges
Case reference 201204677 – Report issued December 2013

Mrs C (through her Advocate) complained about the management of her social housing application and that the Association had overlooked her for properties when she had been top of the list on points. She was at the time in temporary accommodation having been accepted as unintentionally homeless and owed a duty by the local Council. The Council had previously transferred all its housing stock to the Association. Mrs C had held a tenancy with the Association before but there was a dispute as to the circumstances of its termination and sums owed. Mrs C also complained about how her formal complaint to the Association had been dealt with.

The Ombudsman's investigation found that Mrs C had been top of the list for three available lettings but had been overlooked for each one because of the previous tenancy. Whilst the Association could have overlooked Mrs C, the written agreement and process as entered into with other social landlords and the Council, when it took over the housing stock, required that it notify the Council promptly if it were to overlook a top applicant giving its reasons. It did not do so and effectively treated Mrs C as if she was suspended from consideration. Neither had Mrs C been informed so she was denied any opportunity of challenging the decisions and potentially missed out on three allocations. It transpired that all social landlords who were signatories to the agreement also did not in practice follow this process. All were currently reviewing the procedural documentation. Mrs C was subsequently offered, and accepted, a tenancy from another social landlord. The Ombudsman found that the failure to follow due process was maladministration. There was also a failure to have regard to good practice guidance issued by the Welsh Government including in relation to complaints handling. Mrs C's complaint had not been recognised or considered as a complaint quickly enough. This had resulted in a lost opportunity to Mrs C and so injustice to her in remaining in temporary accommodation for longer.

The Ombudsman recommended that the Association should:

(a) apologise to Mrs C;

(b) offer her redress of £1,000;

(c) provide a copy of the new allocations process and any agreement when finalised, and confirm that appropriate staff will be trained in its application;

(d) review its Complaints Policy with a view to adopting the Model Complaints Policy.

Annex B

Public Body Complaints

Statistical Breakdown of Outcomes by Public Body Complaints Investigated

COUNTY/COUNTY BOROUGH COUNCILS

County/County Borough Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Blaenau Gwent	4	2	3		3		1		1	**14**
Bridgend	3	18	13		2			1		**37**
Caerphilly	9	14	10		1		1			**35**
Cardiff	20	28	38		11		1		2	**100**
Carmarthenshire	9	25	19		3		3	2	2	**63**
Ceredigion	7	11	15		4		3		1	**41**
Conwy	8	15	7		2			1		**33**
Denbighshire	5	14	15		1		1		1	**37**
Flintshire	9	12	9	1	4		3		1	**39**
Gwynedd	5	21	5		4		1		1	**37**
Isle of Anglesey	5	4	17				1	1	2	**30**
Merthyr Tydfil	4	7	8		1			1		**21**
Monmouthshire	1	2	4		3		2	1	1	**14**
Neath Port Talbot	11	22	10		1				2	**46**
Newport	3	6	11	1	2					**23**
Pembrokeshire	5	7	19	1	2		1			**35**
Powys	8	17	21		2				3	**51**
Rhondda Cynon Taf	10	20	17		7		3	1	1	**59**
The City and County of Swansea	5	24	26		5		3		1	**64**
The Vale of Glamorgan Council	3	7	10		2		1			**23**
Torfaen	12	6	9				2			**29**
Wrexham	3	20	13		6			2		**44**
TOTAL	**149**	**302**	**299**	**3**	**66**		**27**	**10**	**19**	**875**

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
Fire and Rescue Service										
Mid and West Wales Fire Service	1	1						1	1	**4**
Total	**1**	**1**						**1**	**1**	**4**
National Park Authorities										
Brecon Beacons	2	2	6		1		1			**12**
Pembrokeshire Coast	1	1								**2**
Snowdonia			1		1					**2**
Total	**3**	**3**	**7**		**2**		**1**			**16**

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
Schools Admissions/ Exclusion Appeal Panels										
Admission Appeals Panel – Rhiwsyrdafydd Primary School			1							**1**
Admissions Appeal Panel – Cardiff High School			1		2					**3**
Admissions Appeal Panel – Bedwas Infants School			1							**1**
Admissions Appeal Panel – Castell Alun High School			1							**1**
Admissions Appeal Panel – Cwrt Rawlin Primary School			1							**1**
Admissions Appeal Panel – Hendredenny Park Primary School					1					**1**
Admissions Appeals Panel – Y Pant School			1							**1**
Admissions Appeals Panel – Marlborough Primary School			1							**1**
Total			**7**		**3**					**10**

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
Aberystwyth Town	2									**2**
Amlwch Town			1							**1**
Caldicot Town					1					**1**
Gresford Community			1							**1**
Holyhead Town			1							**1**
Kidwelly Town	1									**1**
Llangelynnin Community			1							**1**
Llannon Community					2					**2**
Llantrisant Community							1			**1**
Mumbles Community	1									**1**
Pembrey & Burry Port Town			1							**1**
Pontypridd Town	1									**1**
Prestatyn Town	1	1	1							**3**
Quarter Bach Community		1								**1**
Rogiet Community							2			**2**
St Arvans Community			1							**1**
Sully Community		1	1							**2**
Total	**6**	**3**	**8**		**3**		**3**			**23**

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
Baneswell Housing Association Ltd					1					**1**
Bro Myrddin Housing Association Ltd		2	1							**3**
Bron Afon Community Housing Ltd		4	2							**6**
Cadwyn Housing Association Ltd	1		1							**2**
Cardiff Community Housing Association Ltd		2	1							**3**
Cartrefi Conwy		5	1					1		**7**
Cartrefi Cymunedol Gwynedd	2	5	7		6					**20**
Charter Housing Association		1			1					**2**
Clwyd Alyn Housing Association Ltd	1	2	5							**8**
Coastal Housing Group Ltd		4	2		2					**8**
Cymdeithas Tai Cantref		1							1	**2**
Cymdeithas Tai Clwyd Cyf		1	1							**2**
Cymdeithas Tai Eryri		1	1							**2**
Cynon Taf Community Housing		1								**1**
Family Housing Association (Wales) Ltd		2	1							**3**
Grŵp Gwalia Cyf Ltd	1	3	4		3					**11**
Gwalia Rest Bay (Co-ownership Equity Sharing) Housing Association Ltd			1							**1**
Hafod Housing Association	1	1	1							**3**
Linc-Cymru Housing Association		1	2							**3**
Melin Homes Ltd					1					**1**

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
Merthyr Tydfil Housing Association Ltd			1							**1**
Merthyr Valleys Homes		3	1						1	**5**
Mid Wales Housing Association Ltd		2	2							**4**
Monmouthshire Housing Association	1	2	3							**6**
Newport City Homes	2	2	3							**7**
Newydd Housing Association		1	1							**2**
North Wales Housing		4								**4**
NPT Homes		6	3		2					**11**
Pembrokeshire Care & Repair	1									**1**
Pembrokeshire Housing Association Ltd					2					**2**
Pennaf Ltd			1							**1**
RCT Homes		2	2							**4**
Rhondda Housing Association Ltd			2							**2**
Seren Group		1								**1**
Taff Housing Association		1								**1**
Tai Calon		3	1		1					**5**
Tai Ceredigion Cyf	1	1	1		4	1				**8**
United Welsh Housing Association		1			2					**3**
Valleys To Coast		3	1		1					**5**
Wales and West Housing Association	1		2		1					**4**
Total	**12**	**68**	**55**		**27**	**1**		**1**	**2**	**166**

LOCAL HEALTH BOARDS AND NHS TRUSTS

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	5	22	25		20	1	24	5	3	**105**
Aneurin Bevan	4	17	27	3	7	1	19	6	5	**89**
Betsi Cadwaladr	2	30	27		12	2	19	4	2	**98**
Cardiff and Vale	2	27	21		18	3	20	6	1	**98**
Cwm Taf	3	17	9	1	9		14	1	2	**56**
Hywel Dda	9	29	17	1	21	1	17	3	3	**101**
Powys Teaching	1	4	13	3	5		1		1	**28**
Public Health Wales	1		1							**2**
Velindre		1	2				1		1	**5**
Welsh Ambulance Services	1	6	6		2		1	2		**18**
Total	**28**	**153**	**148**	**8**	**94**	**8**	**116**	**27**	**18**	**600**

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
Board of Community Health Councils			1							**1**
Dentist	2	4	2	1	3		4	3		**19**
GP	5	34	33	5	12		19	16	2	**126**
Opticians					1			2		**3**
Pharmacist			1				1			**2**
Independent Health Provider – Spire Cardiff Hospital								1		**1**
Total	**7**	**38**	**37**	**6**	**16**		**24**	**22**	**2**	**152**

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	1	3						2	**9**
CSSIW	3		2				1	2	1	**9**
Healthcare Inspectorate Wales							1			**1**
Independent Complaints Secretariat			3							**3**
Planning Inspectorate		1	3		1					**5**
Valuation Tribunal for Wales West Wales Region			1							**1**
Visit Wales		1								**1**
Welsh Government	2	6	17	1	1				1	**28**
Total	**8**	**9**	**29**	**1**	**2**		**2**	**2**	**4**	**57**
Welsh Government Sponsored Bodies										
Cadw			1							**1**
Care Council for Wales	1									**1**
Environment Agency	1	1								**2**
Natural Resources Wales	2	6	3		1					**12**
Welsh Language Commissioner			1							**1**
Total	**4**	**7**	**5**		**1**					**17**
OVERALL TOTAL WELSH GOVERNMENT AND ITS SPONSORED BODIES	**12**	**16**	**34**	**1**	**3**		**2**	**2**	**4**	**74**

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	3		1						1	**5**
Body out of jurisdiction	1									**1**
Total	**4**		**1**						**1**	**6**

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	2		1					**3**
Bridgend	4							**4**
Caerphilly	4			2			1	**7**
Cardiff	5		1				1	**7**
Carmarthenshire	1						3	**4**
Ceredigion	2							**2**
Conwy	1							**1**
Denbighshire	2						2	**4**
Flintshire	2	2						**4**
Gwynedd	4							**4**
Isle of Anglesey	1			1				**2**
Monmouthshire	1	2						**3**
Newport	8							**8**
Pembrokeshire	3			1	1			**5**
Powys	1		2					**3**
Rhondda Cynon Taf	14						1	**15**
Swansea	22	2	5	1				**30**
The Vale of Glamorgan							1	**1**
Torfaen	5			1				**6**
Wrexham	1							**1**
Total	**83**	**6**	**9**	**6**	**1**		**9**	**114**

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
Aberffraw Community	1							**1**
Ammanford Town	1							**1**
Bangor City	1							**1**
Bargoed Town	1							**1**
Blaengwrach Community		1		1				**2**
Blaenrheidol Community	1							**1**
Bridgend Town	1							**1**
Brymbo Community	1							**1**
Caldicot Town	1							**1**
Cefn Community			1	2				**3**
Coity Higher	1							**1**
Colwinston Community					2			**2**
Connah's Quay Town	1							**1**
Cowbridge with Llanblethian Town	3							**3**
Cwmbran Community	1							**1**
Forden Community		1						**1**
Glynneath Town	1							**1**
Goldcliff Community	1							**1**
Gorseinon Town					1			**1**

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
Gresford Community	2							**2**
Hay-on Wye Town	1							**1**
Hirwaun & Penderyn Community	2							**2**
Holyhead Town	1							**1**
Kidwelly Town	1							**1**
Killay Community	1							**1**
Knighton Town	2							**2**
Laleston Community	1							**1**
Langstone Community	2							**2**
Llanbadrig Community	1							**1**
Llandrindod Wells Town	2			1		1		**4**
Llandudno Town	3							**3**
Llanelli Rural							2	**2**
Llanfaelog Community				5				**5**
Llanfynydd Community [Carmarthenshire]	3							**3**
Llangennith, Llanmadoc & Cheriton Community	2							**2**
Llangwm Community [Pembrokeshire]	1							**1**

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
Llantrisant Community	1							**1**
Llanwrtyd Wells Town	1							**1**
Mathry Community	1							**1**
Montgomery Town	1							**1**
Mumbles Community	26							**26**
Nelson Community	2							**2**
Old Radnor Community	1							**1**
Old St. Mellons Community Council	1							**1**
Pembrey & Burry Port Town	1							**1**
Penmaenmawr Town	1			1				**2**
Pennard Community	2							**2**
Porthcawl Town	1							**1**
Prestatyn Town	8						1	**9**
Rogiet Community	1			1				**2**
St Florence Community	2							**2**
Sully Community					1			**1**
Talgarth Town	1							**1**
Trellech United Community	1							**1**
Total	**93**	**2**	**1**	**11**	**4**	**1**	**3**	**115**

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 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 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.

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