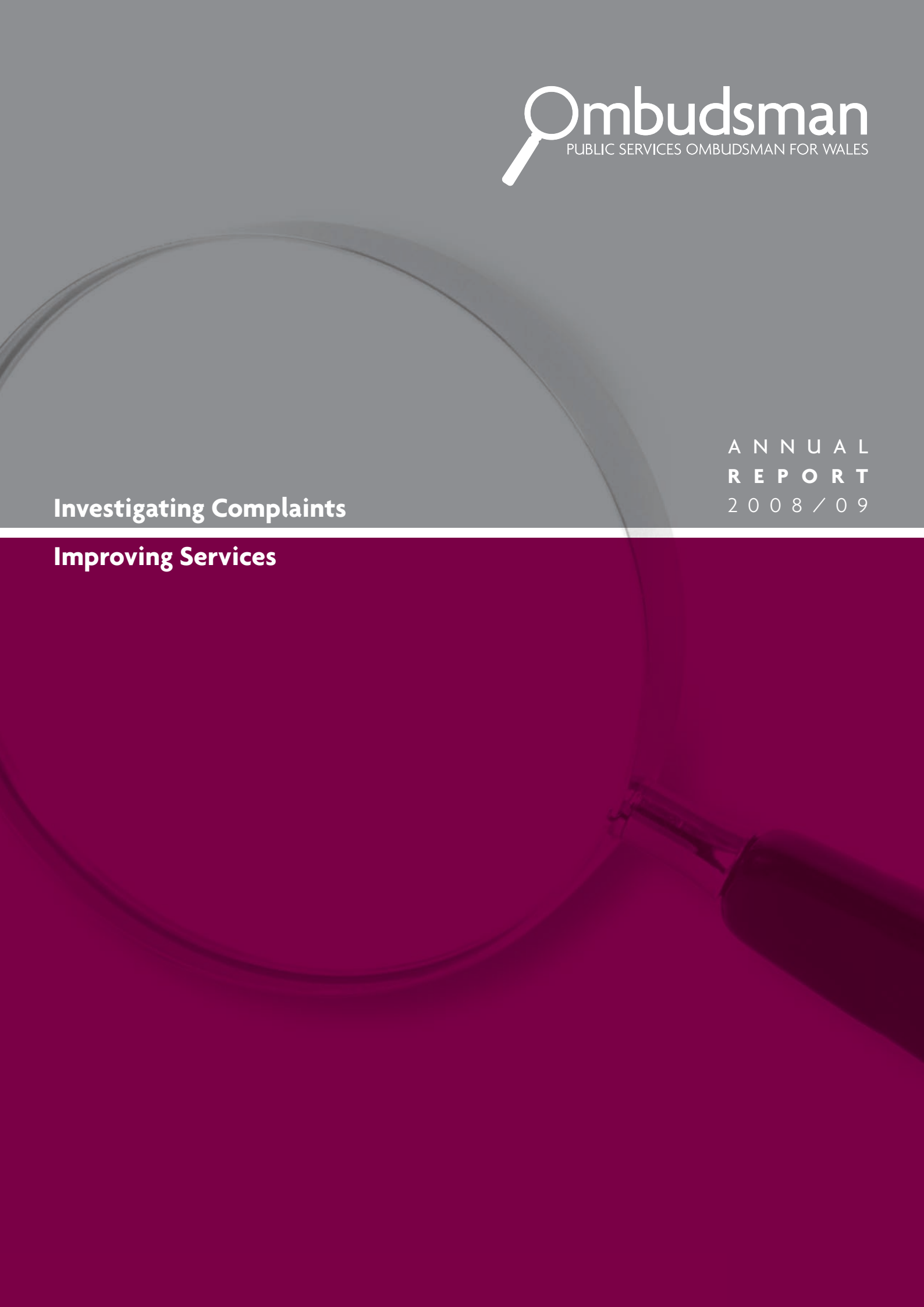
Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

ANNUAL
REPORT
2008/09

Investigating Complaints

Improving Services



The Annual Report 2008/09

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

Annual Report 2008/09

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

1 Introduction

I am pleased to introduce this annual report following my first year as Public Services Ombudsman for Wales. My predecessor, Adam Peat OBE was the first to hold the office having successfully brought together the three jurisdictions of the Commissioner for Local Administration in Wales, the Welsh Administration Ombudsman and the Health Service Commissioner for Wales to create a unified Ombudsman scheme for Wales.

The service I took on was well-established and effective. It was also under enormous pressure, as a result of a steadily growing number of complaints from members of the public in Wales. The most striking aspect of the work remains the stories of the individual service users who are unhappy about the service they have received or the way they have been treated. In many instances, I cannot uphold their complaints because the complaint falls outside my remit, or because they have not yet complained to the body concerned or because there is no evidence that the body they complained about has been guilty of maladministration or service failure. In other instances, although people are unhappy, they have not suffered a personal injustice. Even where I do not uphold complaints, however, there are many instances where it is impossible not to be touched by the hurt that individuals are suffering.

On the other hand, the complaints which I do uphold reveal instances of injustice which have often blighted the lives of the people concerned or their families. In the past year I have upheld complaints where individuals have suffered years of harassment as a result of failure to deal with nuisance neighbours and people whose hospital treatment has fallen well short of an acceptable standard. I also see cases where people have not had funding to which they were entitled, or vital services, treatment or adaptations. It is a privilege to be able to address these issues for individuals, but also to contribute to changes in the way services are provided or managed which mean that future service users will not suffer from the same shortcomings. In this regard, I would like to mention the prompt and effective response of the Welsh Assembly Government in addressing cases where service users lost out as a consequence of public bodies arguing about who should provide a service.

The large increase in complaints since the service's inception has unfortunately taken its toll on performance this year. The increased volume of and the growing complexity of complaints has meant that the time taken to investigate some has extended. This has been exacerbated by the increase in health complaints, probably as a consequence of the high profile achieved by some reports in the early part of the year rather than as a consequence of a deterioration in service quality, although it is not possible for me to reach a firm conclusion solely on the basis of the complaints I receive.

The majority of complaints to my service continue to be about services provided by local authorities, not least because local councils provide such a high proportion of public services in Wales. Planning and housing complaints are the most numerous of these, but they have been surpassed for the first time this year by complaints about health services. There has not been an increase in complaints about local authorities.

The second role of my office relates to complaints that members of local authorities and community councils have breached their Code of Conduct. Many of the complaints I receive relate to robust

political debate, and although I would not wish in any way to hinder democratic dialogue, I remain concerned about the lack of respect shown by a minority of Councillors both towards other members and towards officers. I would very much welcome an improvement in this regard.

I have during the year developed a new strategic plan for the three years ahead. This has been prepared in response to service pressures and reflects the views expressed by service users. I am grateful to my staff for their considerable input into its preparation. It is designed to reflect the increasing maturity of the service and to offer a better response to complainants, not least in helping them to fully understand what the service can offer them at the point at which they first make contact. It is also designed to reduce bureaucracy and streamline the service offered to complainants. I want the service to be ever more accessible to people who depend most on public services. These include many individuals who are vulnerable and at risk of exclusion and it is essential that they can feel confident that their complaints will be valued and properly investigated. My outreach for the coming year will also reflect this aspiration.

The importance of learning the lessons of complaints cannot be underestimated. While some complaints arise from individual circumstances and are unlikely to be repeated, others flow from failures of management, of training, of systems or regulation. During the year many reports have sought to draw these lessons, and we have worked to ensure that they are effectively drawn to the attention of the appropriate audiences, whether they are the leaders of the services concerned, or more widely to regulators and representative bodies. In this way the service has offered both redress for individuals and service improvement.

The work of the office has revealed many instances where poor service has been exacerbated by poor complaint handling and, indeed, where the service offered did not fall short of the required standard but the subsequent complaints management was not acceptable. There is a considerable variation in practice in this regard, and I have been glad to have an opportunity to contribute to the work of the Welsh Assembly Government in developing a new redress system for the NHS in Wales, and I look forward to its introduction. In addition, I have been involved in the early discussions which are looking to bring a greater consistency to the management of complaints across all of the public services which fall within the remit of the Welsh Assembly Government, and I very much welcome this initiative.

I would like to take this opportunity to pay tribute to the work of my staff during the year. They have demonstrated great expertise and effectiveness, and are motivated by a strong commitment to excellent public services which have the individual service user at their heart.

Finally, I would like to place on record my sincere congratulations to my predecessor, Adam Peat, whose work as Public Services Ombudsman for Wales as well as his distinguished career in public service in Wales was recognised by the award of an OBE in the New Year's Honours List.

Peter Tyndall
Ombudsman

2 The Role of the Public Services Ombudsman for Wales

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

Complaints about public bodies in Wales

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

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

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

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

The Public Services Ombudsman (Wales) Act 2005 provides for two types of report for reporting formally on my investigations. Reports under section 16 of the Act are public interest reports and almost all are published. The body concerned is obliged to give publicity to such a report at its own expense. Where I do not consider the public interest requires a section 16 report (and provided the body concerned has agreed to implement any recommendation I may have made) I can issue a report under section 21 of the Act. There is no requirement on the body concerned to publicise section 21 reports, although details of them can be found on my website and copies are usually available from my office on request.

Occasionally, I need to direct that a report should not be made public due to its sensitive nature and the likelihood that those involved could be identified. For technical reasons, such a report is issued under section 16 of the Act, even though it is not a public interest report, and I make a direction under section 17 of the Act. There have been a few such reports issued this year.

The Public Services Ombudsman (Wales) Act 2005 also gives me the power to do anything which is calculated to facilitate the settlement of a complaint, as well as or instead of investigating it. In the right circumstances, a 'quick fix' without an investigation can be of advantage to both the complainant and the body concerned. I am pleased that it has been possible to increase the number of cases settled in this way this year, but I will be looking to make greater use of this power in the future.

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

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

In circumstances where I decide that a complaint should be investigated, under legislation there are four findings that I can arrive at:

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

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

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

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

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

3 Complaints of Maladministration and Service Failure

Overview

The number of complaints about maladministration or service failure by public bodies has continued to rise, as illustrated by the table below. The first three years since the PSOW office came together in shadow form (2005/06) saw a year on year 10% increase in the number of new cases being received. The past year was a somewhat curious one in this regard. The first six months saw an increase of 29% compared with the same period in the previous year. However, the overall position at year end was that there was an increase of 6% compared to the number of complaints received during 2007/08.

I believe that the increase during the first half of the year arose from two main factors: the first was the publicity the service received surrounding my appointment as Ombudsman in April 2008; the second, was due to the high level of media attention that a number of health investigation reports received around the same period.

	Total Number of Complaints
Cases carried over from 2006/07	457
Cases reopened in 2007/08	11*
New cases 2007/08	1,420
Total complaints 2007/08	**1,888**
Cases carried over from 2007/08	445
Cases reopened in 2008/09	6*
New cases 2008/09	1,501
Total complaints 2008/09	**1,952**
Cases to be carried forward to 2009/10	**585**

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

In addition to the above, the office also dealt with **813 enquiries** during 2008/09, compared with 1,046 during 2007/08. Enquiries are contacts made by potential complainants asking about the service provided, which do not in the end result in a formal complaint being made to me.

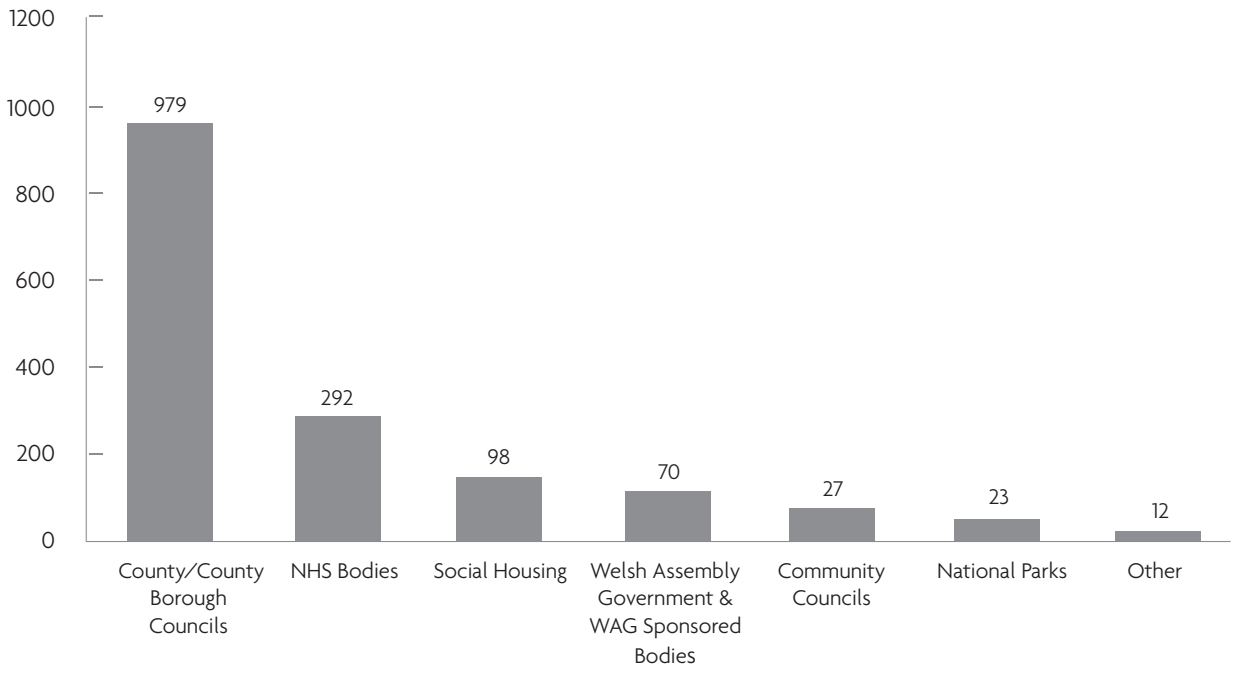
It is also worth noting the impact that the continued increase in complaints is having in relation to the number of cases in hand at my office at any one time. In particular, 585 cases were carried forward to 2009/10, compared with 445 cases that were brought forward to 2008/09.

Sectoral breakdown of complaints

The pattern of previous years is that the vast majority of complaints received are in respect of county councils. As the chart overleaf shows, this continues to be the case and is to be expected given they are direct providers of a wide range of services to the public. However, the level of complaints about this sector of the public service has remained fairly constant (979 in 2008/09 compared to 984 in the previous year).

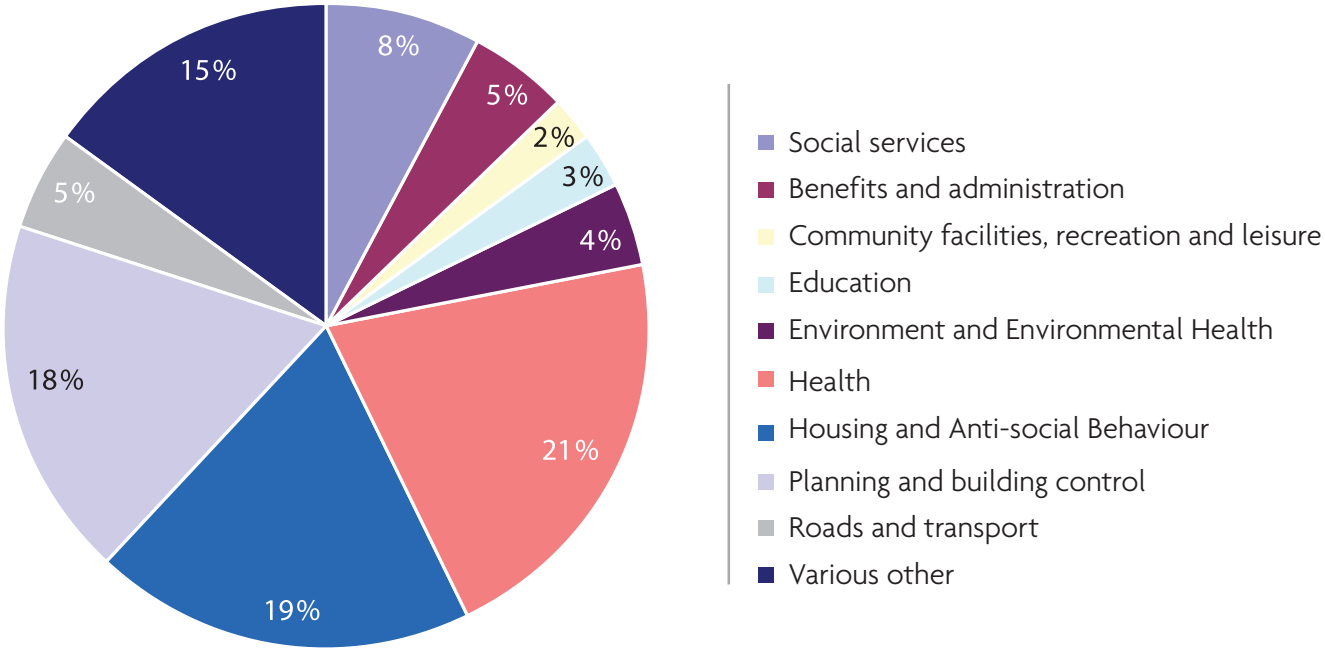
On the other hand, complaints in respect of NHS bodies increased noticeably over the past year (292 compared with 232 in 2007/08). The increases were in the areas of clinical care and continuing health care. The rise in the clinical care complaints, in particular, coincided with the media attention that a number of health public interest reports issued at the beginning of 2008 had attracted. I will address these two issues further later in this report.

The number of complaints against other sectors remains relatively low, however, this can largely be attributed to the fact that for some (such as community councils and the Welsh Assembly Government) the extent of the services directly provided to the public are, in comparison to county councils and NHS bodies, fairly limited.



Complaints about Public Bodies by Subject

Historically, housing and planning complaints have been the most numerous complaints received. In 2007/08, housing complaints accounted for 23% of the caseload, planning complaints 21% and health 16%. However, I have already alluded to the fact that 2008/09 saw an increase in complaints about health bodies and as can be seen from the chart below, health complaints – for the first time - have been the most numerous type of complaint (21%).



Outcomes of Complaints Considered

An overall summary of the outcomes of the cases closed during the past year, together with a comparison of the position last year is given in the table below. The number of cases closed over the past year is slightly down on 2007/08. However, this can be partly attributed to the fact that a far larger number were accepted for investigation than previously (241 compared to 118). These investigations were then discontinued (for example, when it became evident at an early stage that there was no maladministration or hardship), but this has meant a greater investment of time in dealing with these cases. Another factor, is that some investigations are becoming more complex – particularly those involving more than one public body.

Nevertheless, despite the increase in the number of complaints received, compared to the position in 2007/08 there were only 7 more complaints upheld (either in whole or in part or via a voluntary settlement). Accordingly, this suggests that in terms of service delivery, public bodies in Wales are maintaining their level of performance.

(A breakdown by listed authority of the outcome of complaints investigated during 2008/09 is set out at Annex B.).

Complaint about a Public Body	2008/09	2007/08
Decision not to investigate	876	975
Complaint withdrawn	45	30
Complaint settled voluntarily (including "quick fix")	65	40
Investigation discontinued	241	118
Investigation: complaint not upheld	55	164
Investigation: complaint upheld in whole or in part	115	139
Investigation: complaint upheld in whole or in part – public interest report	25	19
Total Outcomes – Complaints	**1,422**	**1,485**

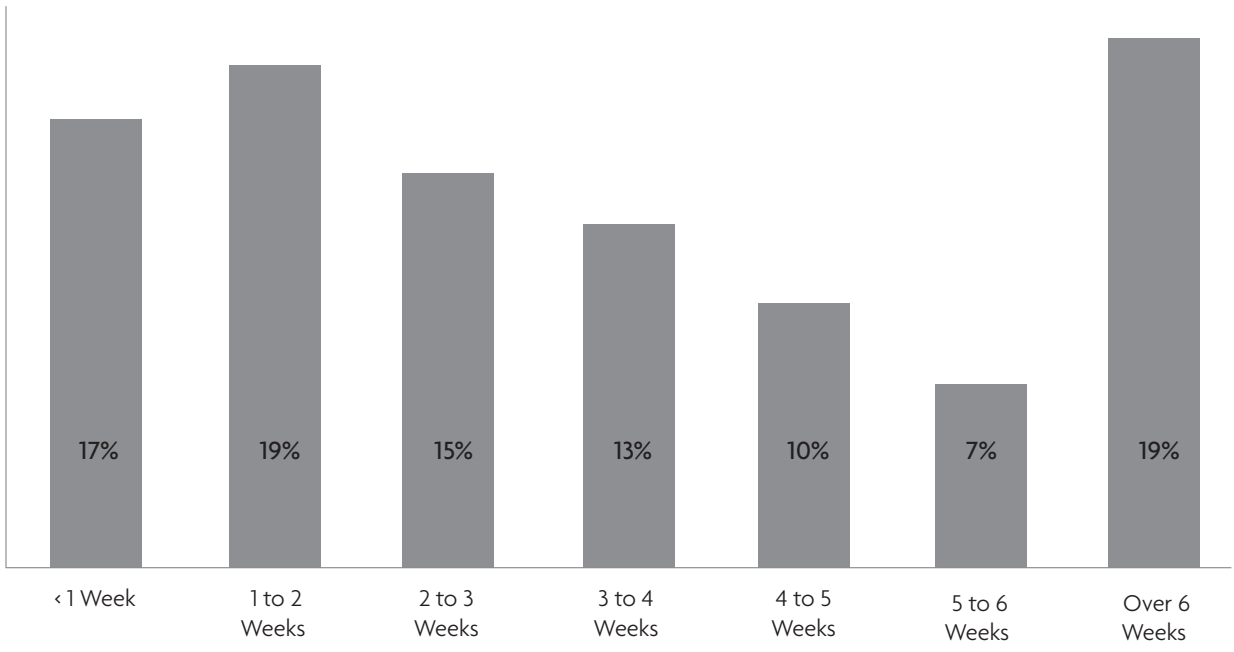
Decision Times

The Strategic Plan set two specific targets for 2008/09 in relation to times for complaint handling:

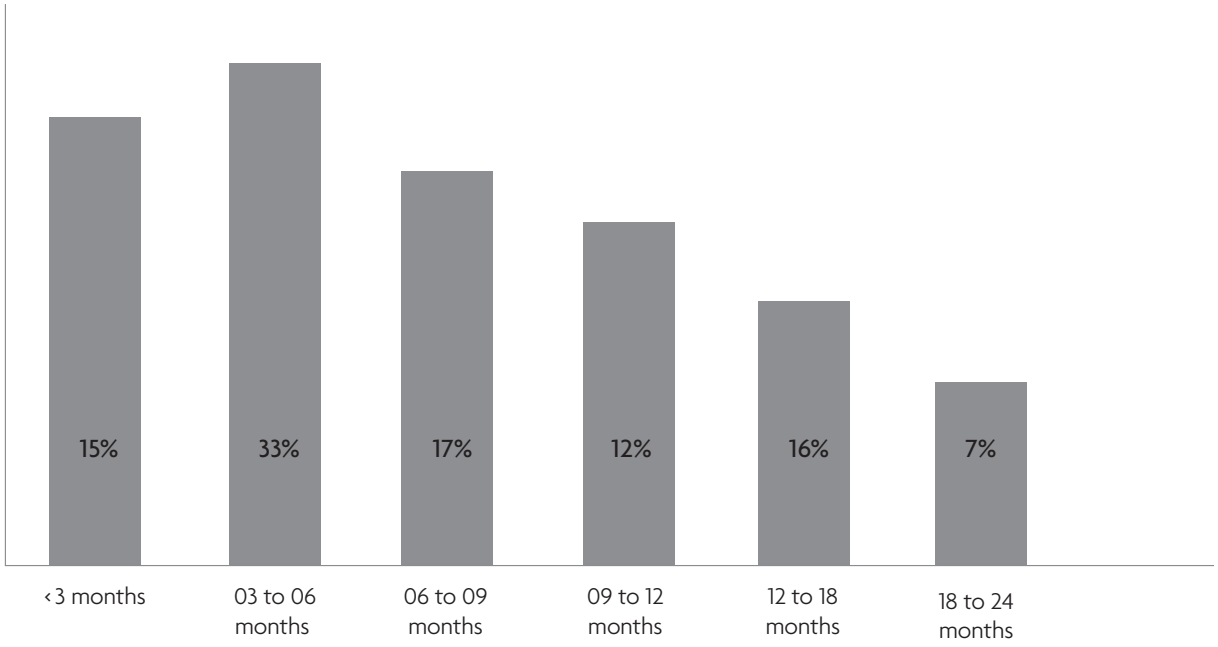
- the first was to tell complainants within 4 weeks whether the Ombudsman will take up their complaint. This was achieved in respect of 64% of complaints.
- the second target was to conclude cases within 12 months from the point that a decision is made to take up a complaint (that is, to commence investigation of a complaint). This was achieved in respect of 77% of cases.

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

Decision times for informing complainants if complaints will be taken up



Decision times for concluding investigations of public body complaint cases



In both respects these outcomes are disappointing. However, there are two factors that have a bearing on this situation. During the first half of 2008/09 my office saw an unprecedented increase in the number of complaints received (at the end of September this stood at a 29% increase on the same period the previous year). This in particular, had an impact on our ability to assess the complaints received and we had to take the step of notifying complainants that the backlog was such that it would likely be eight weeks before we would be able to let them know if their complaint would be taken up.

As far as time taken in relation to complaints which are investigated is concerned, whilst it is good to see that almost half of these are concluded within six months, it is a matter of considerable concern that a significant proportion are taking over 12 months. Part of the reason for this lies in the fact that an increasing number of cases are becoming more complex in their nature (as I have already explained earlier in this chapter). The higher proportion of health cases certainly contributes to this as there are usually very extensive records, and professional advice is very often required. There have also been some significant delays in receiving comprehensive responses from bodies in jurisdiction. In addition, many cases require large numbers of interviews to be conducted and considered.

[Note: It is not possible to make a direct comparison with the previous year in relation to the above targets since these were amended for 2008/09. However, comparing the outcomes on the targets as set for 2007/08 the position would be:

Decision Letter times - notifying complainant as to whether complaint will be investigated or not

	2008/09	2007/08
Within 3 weeks	52%	55%
Within 6 weeks	82%	87%

Decision times for concluding public body complaint cases (including those not taken to investigation stage)

	2008/09	2007/08
Within 3 months	70%	72%
Within 6 months	83%	81%
Within 9 months	88%	86%
Within 12 months	92%	92%
Within 18 months	97%	98%

Joint Investigations

Under the PSOW Act, I am also able to co-operate with other Ombudsmen. During the year, I conducted joint investigations with colleague Ombudsmen in England. One joint investigation was with the Local Government Ombudsman in England. This related to a case where a husband and wife complained about the way in which information about their family had been transferred between the social services department of a county council in England and a social services department in a county council in Wales. That complaint was upheld.

I also commenced an investigation of a complaint with the Parliamentary and Health Services Ombudsman in England. This investigation concerns a woman living in Wales but taken ill during a stay in England. The complaint involves a dispute over the woman's care and also the funding of her treatment. It involves a Primary Care Trust in England, Health Commission Wales and an NHS Trust in Wales.

4 Code of Conduct Complaints

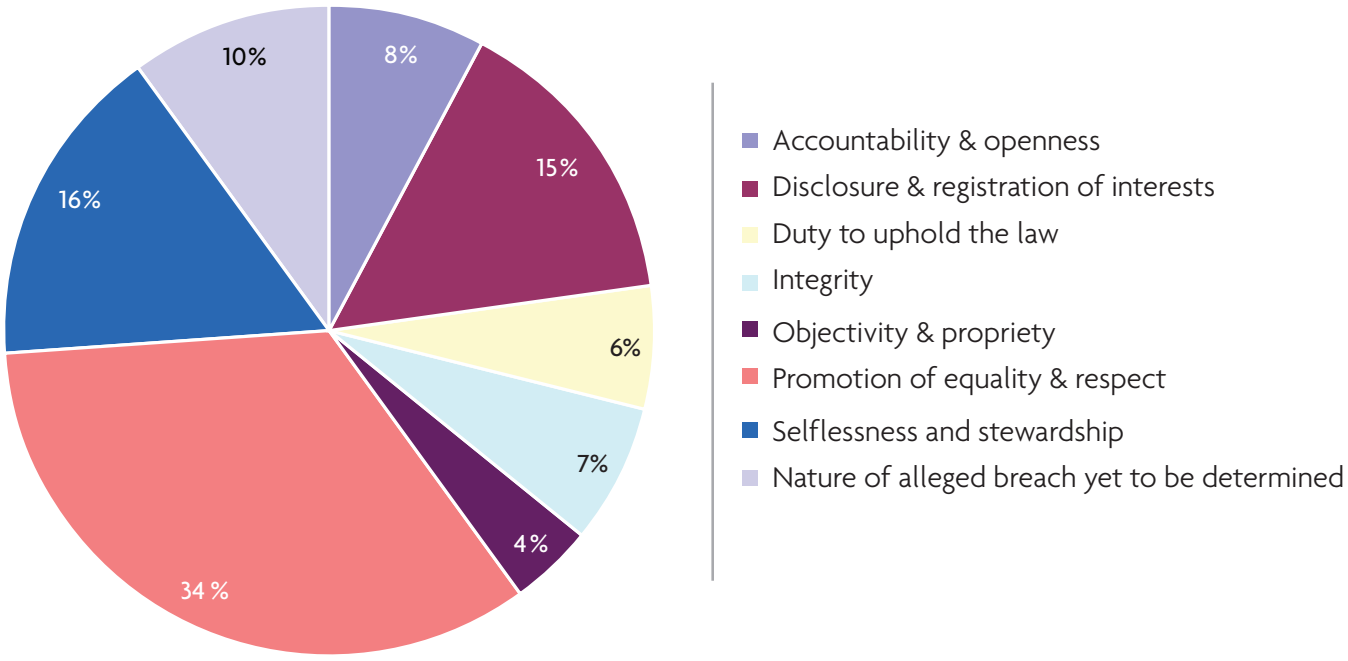
Complaints Received

The table below gives a breakdown of the code of conduct complaints received by type of authority. This shows that overall there has been an increase in the number of complaints received. In particular, it is concerning to see that the decline in the level of complaints made against community councillors that was reported in 2007/08, was reversed during the past year with the number of such complaints having doubled. There is no significant change to the level of complaints received against county councillors.

	2008/09	2007/08
Community Council	132	65
County/County Borough Council	153	160
National Park	-	4
Police Authority	-	1
Total	**285**	**230**

Nature of Code of Conduct Complaints

Of the areas of the Code that members were alleged to have broken, the most common type of complaint is a failure in relation to 'equality and respect'. As the chart below shows, this accounted for 34% of the complaints received.



Summary of Code of Conduct Complaint Outcomes

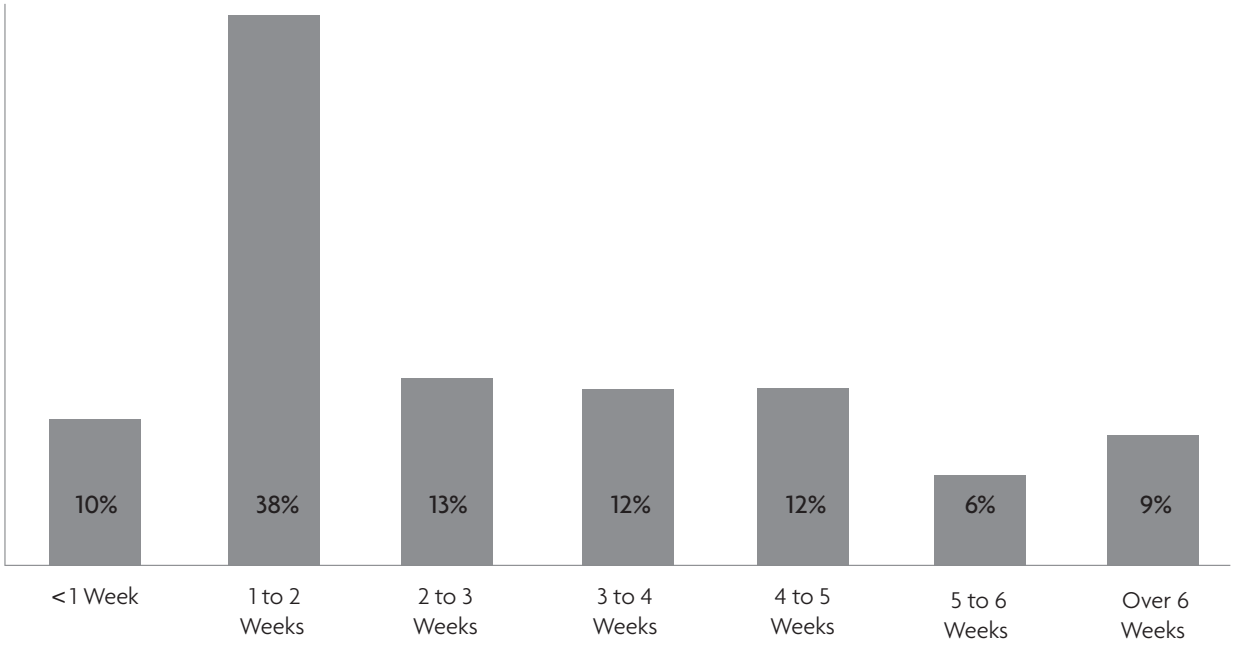
Of the Code of Conduct cases considered in 2008/09 it was decided that the large majority did not call for an investigation. The number of cases that I concluded warranted referral to either an authority's standards committee or to the Adjudication Panel for Wales is similar to that of the previous year, that is: 8 compared to 9 in 2007/08.

	2008/09	2007/08
Decision not to investigate complaint	184	153
Complaint withdrawn	17	1
Investigation discontinued	4	28
Investigation completed: No evidence of breach	3	12
Investigation completed: No action necessary	15	8
Investigation completed: Refer to Standards Committee	5	6
Investigation completed: Refer to Adjudication Panel	3	3
Total Outcomes – Code of Conduct complaints	**231**	**211**

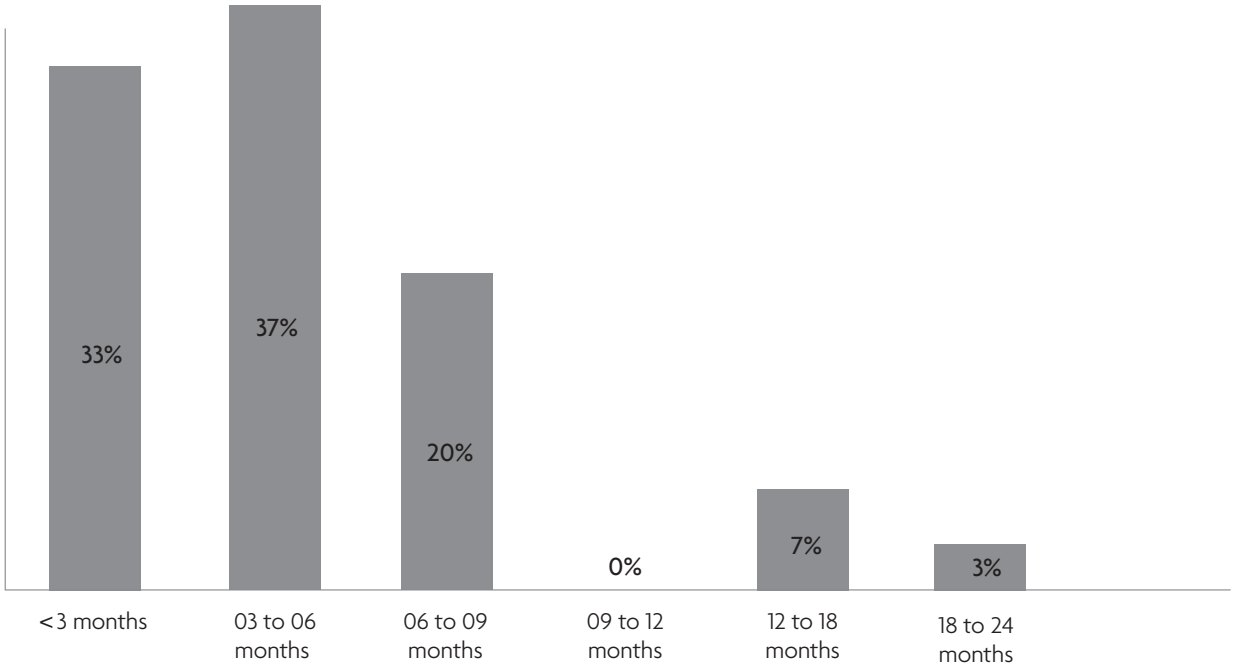
Decision Times

Being the subject of a Code of Conduct complaint is generally a stressful circumstance for a councillor to find themselves in. This is often heightened by the media speculation that frequently surrounds such complaints. I am pleased, therefore, that as the charts below show, in almost half of complaints received, a decision as to whether or not to investigate the complaint was taken within a fortnight; and that 90% of those cases investigated, were concluded within 9 months - the remaining 10% (or 3 cases) took over 12 months.

Decision times for informing complainants if code of conduct complaint will be taken up



Decision Times for concluding Code of Conduct complaint cases



However, investigations of Code of Conduct complaints are becoming more complicated (and more resource intensive). For example, a case that began towards the end of 2008 and, still underway at the time of writing, involves some 70 interviews with members and officers of one particular county council. Furthermore, investigations more and more are being undertaken to criminal investigation standards. This is as the result of members who are the subject of an allegation increasingly engaging legal representation. Thus, my investigations in relation to Code of Conduct complaints are changing in nature. They are now becoming more adversarial rather than inquisitorial. This is, in my view, a regrettable development.

New Code of Conduct for Local Authority Members

Meetings with local authority monitoring officers during the past year suggested that guidance on the new Code of Conduct would be welcomed. Towards the end of the year, I consulted local authorities on which aspects of the Code they would in particular appreciate guidance upon. Responses have now been received and work will be undertaken during 2009/10 to issue guidance.

Police Authorities

During a meeting held with Police Authorities in Wales, concern was expressed that while Code of Conduct complaints in respect of Police Authority Members were subject to investigation by the Public Services Ombudsman for Wales, the Code which applied was that relevant to local authorities in England. It was pointed out that this is confusing to Police Authority Members who frequently are also county council members in Wales, and thus have to have regard to two different Codes. I undertook to raise this matter with the Welsh Assembly Government.

Whilst the primary concern in relation to complaints about public bodies is to secure justice for individuals (i.e. those complainants who have received a poor service or have been treated unfairly as a result of maladministration), I also take the view that there is an important role for an Ombudsman beyond this by helping to improve the services provided by public bodies through sharing the lessons that can be learnt from the investigations that I undertake. This can be done in many ways and I will refer to some below.

Section 21 Reports

The majority of reports which are issued are not formally publicised because the issues raised are not considered to be of public interest. Nonetheless, these reports often identify failings within the body concerned which it agrees to rectify as part of the recommendations in the report. This can include, for example, improved training, changes to management practices or improved procedures. On occasions, even where an investigation is discontinued because the body concerned agrees to provide the service or rectify a service failure, they can also agree to make changes designed to ensure the same failing will not happen again.

Public Interest Reports

Issuing a public interest report, under section 16 of the PSOW Act can achieve more than redress for the individual. I regularly make recommendations to make sure that where systemic problems have been identified the body concerned puts procedures in place to ensure that such problems do not happen again in the future. Publishing these reports also means that the attention of members of the public in receipt of services from the body in question are also alerted to the problems that existed; it may be that they too have suffered a similar case of maladministration and may wish to make a complaint. These public interest reports also mean that there can be wider learning among similar public bodies, which can look to see that there is no similar systemic problem existing in their own organisation.

There were 25 public interest reports issued in 2008/09 (a 32% increase on the previous year). Summaries of each of these are at Annex A and their full text is available on my website at **www.ombudsman-wales.org.uk**

Extra-ordinary Reports

The PSOW Act also enables the Ombudsman to issue an 'extra-ordinary report'. Such a report issued to local authorities in the past related to 'Homelessness and Housing Allocations'. I have already referred in this Annual Report to the health cases that attracted media attention at the beginning of 2008. These cases presented themselves as being ones that could indeed form the basis of such an extra-ordinary report. However, in this instance, I decided that it would likely be more effective to draw the matter and my concerns to the attention of the Minister for Health and Social Services at the Welsh Assembly Government. Following a succession of complaint investigations undertaken, it was apparent that health bodies in Wales were more concerned with protecting their own budgets rather than putting the needs of patients first. The most recent example of these cases can be found on page 32 of this Annual Report.

I am pleased to say that the Minister for Health and Social Services responded promptly to this matter and in June 2008 issued a Circular to health bodies in Wales, strengthening existing guidance that was in place. I very much hope, therefore, I will not have to consider complaints of this nature in the future.

Continuing Health Care Funding

Another provision in the PSOW Act is that I may find an alternative means to resolve complaints. I have commented above on the increase in the number of public interest reports that I issued over the last year. A notable number contributing to this increase relates to delays in the consideration of reviews of applications for continuing health care funding by Local Health Boards. Furthermore, a significant number of such cases were under consideration at the end of March 2008 and I am aware that there are likely to be many more on their way to my office. In view of the substantial number of complaints relating to the same concerns, I have decided in this instance to explore whether it will be possible to achieve a resolution to this situation without investigating each single complaint. At the time of writing I am meeting with officials at the Welsh Assembly Government to consider this situation and seek to achieve a solution.

Guidance by the Ombudsman on Good Administrative Practice

Under section 31 of the PSOW Act I have a power to issue, following consultation, formal guidance to bodies in my jurisdiction about good administrative practice. Complaints handling and redress are clearly an area of administrative practice on which the Ombudsman is well placed to give guidance. Guidance issued in previous years under this section includes, for example, 'Guidance on Good Complaint Handling for Local Authorities', 'Principles of Good Administration' and 'Principles for Redress'.

During the past year, however, rather than issue guidance myself, I have instead contributed to work being undertaken by the Welsh Assembly Government. First, I was a member of the Welsh Assembly Government's NHS 'Putting Things Right Project' looking at NHS Redress and complaint handling

arrangements. The work of the Project Board has now concluded and its recommendations have been put out to consultation. Secondly, the Welsh Assembly Government is considering developing a common complaints handling process for public bodies in Wales. At the invitation of the Minister for Finance and Public Services, I submitted a paper which set out the potential and benefits of such an arrangement. At the end of 2008/09 senior officials have been tasked with developing concrete proposals to move this forward, and I am happy to have the opportunity to contribute to its development.

Outreach – Bodies in Jurisdiction

There are also more general lessons that can be learnt from complaints that do not necessarily warrant the formal approach of issuing a report etc. Opportunities are sought to share these with bodies in jurisdiction in a more informal manner. In October 2008, an outreach road show was held throughout Wales. During this, sessions were held for bodies in jurisdiction. On this occasion the theme – regardless of whether the audience was representatives from local authorities, health bodies, or social housing organisations – was 'lessons learnt'. This provided an opportunity not only for my staff and me to share the lessons arising from complaints investigated, but also to have an open and constructive dialogue about the service I provide. From the feedback received, these sessions were very well received by those who attended; certainly my staff and I found them useful.

Apart from the structured approach of outreach roadshows, my staff and I have on numerous occasions throughout the past year given talks to the staff of bodies in jurisdiction in relation to the work of my office and how to respond to and handle complaints. I have also developed and strengthened links with professional and representative bodies to create an effective channel for getting messages from complaints into the services concerned.

6 Accessibility and External Communication

It is important to me that my service should be open to everyone who uses public services in Wales. I am particularly keen that this is the case for disadvantaged or vulnerable people, given that these are often the very people who make the greatest use of public services. It is important that they know that they have someone they can complain to – on a confidential basis – if they feel that they have received a bad service or have been treated unfairly by a public body in Wales. I am conscious that simply removing barriers, important though that is, is not enough of itself. It is also critical that the service reaches out to individuals and communities who might not otherwise believe that it was for them.

Outreach – Voluntary and Advocacy Organisations

I have previously referred to the series of outreach meetings held throughout Wales. At this time, my staff and I met with representatives of a wide range of voluntary and advocacy organisations. I have to say that I was very heartened by the number of people that attended these sessions. We discussed how voluntary and advocacy organisations might be able to raise awareness of the Ombudsman's service among those people who come to them for assistance; the advice/advocacy support they might be able to provide to someone wishing to make a complaint against a public body; and whether my service could be improved to make dealing with my office easier for disadvantaged or vulnerable people. Again, the feedback received immediately after the event and subsequently was that voluntary organisations found these meetings very useful and helpful, as indeed did my staff and I.

Furthermore, prior to the above road show, I held a number of individual meetings with leaders of voluntary organisations to hear their own experiences of issues surrounding complaints about public bodies. This proved very useful, and was also the catalyst to the production of articles for their newsletters and journals about the role of the Ombudsman and how I might be able to help their clients.

'How to complain' Leaflet

Currently this is the key piece of literature issued that explains to members of the public the role of the Ombudsman and how they may complain. The leaflet as well as being in Welsh and English, is also available in the Bengali, Cantonese, Urdu, Polish and Somali languages. It has also been produced on tape and CD. It is intended that this leaflet will be revised in the forthcoming year and that it will be supplemented by fact sheets giving further advice relating to specific areas of complaint (e.g. homelessness or anti-social behaviour).

Website

Research and equal opportunities monitoring activities reveal that the website is now an important channel through which people find out about the Ombudsman's office. In recognising the importance of this medium as a means of reaching out to people, my website has been redesigned this year. It now gives much more prominence to the core activity of my office, i.e. considering complaints, and is more 'user-friendly' to those seeking to find out how to make a complaint to me. It is intended to continue to develop the information provided on the site over the forthcoming year.

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

Audit Committee

The use that I make of the resources available to me is subject to the scrutiny of the Wales Audit Office, which audits my accounts. The activity of auditing my accounts was outsourced by the Wales Audit Office in 2008/09 to Grant Thornton. This arrangement has worked well from my perspective. The Auditor General, however, remains ultimately responsible for the external audit function.

Although a 'corporation sole', an Audit Committee had previously been established and charged with advising the Ombudsman in discharging his duties as Accounting Officer. Mr Laurie Pavelin CBE FCA agreed to take on the role of chairman and I am pleased to say that he agreed to the extension of his contract for a further two years (to 31 March 2011).

The Audit Committee reviewed its terms of reference and membership at the end of the year. The Committee's remit has now been extended to include consideration of issues such as the Strategic Plan and the level of independent membership is to be increased.

RSM Bentley Jennison act as my internal auditors and their programme of work is guided and overseen by the Audit Committee. The Audit Committee met four times during 2008/09 and I am pleased that no substantive matters of concern were raised during this time.

Future Strategic Direction

During this past year, considerable attention has been given to the strategic direction of this office. A new Three Year Strategic Plan has been developed. This is intended to move the service forward making it more accessible, more customer-focussed and more streamlined. It takes account of the work of all-staff seminars held during November and the views expressed by complainants about the service they have received. A new vision and new values have been developed and our purpose restated (see page 28) and the Plan is intended to take the organisation forward into its next phase of development.

The Plan is available on my website **(www.ombudsman-wales.org.uk/publications)**. I would particularly want to draw attention to the 'Managing Expectations' project, an integral part of this strategy which got underway at the end of 2008/09. We recognised during the course of last year that there is a real need for change in the way we undertake our role. The drivers include:

(a) **Increased demand** – there has been a substantial increase in the number of complaints received. It was felt (and the end of year statistics that appear in an earlier section of this report support this) that the system we currently have may not be sustainable for the volume of complaints we are now dealing with. In particular, it is felt that a greater investment in 'first contact' could help in reducing the number of complaints we receive which at assessment stage in our process reveal themselves to be premature or out of jurisdiction.

(b) **Unduly complex process** – We will seek to revise our existing complaints procedure so that it will be less onerous and less bureaucratic, with a view to being able to close cases more quickly.

(c) **Complainant Satisfaction Survey** – Compared to other Ombudsman services we are on a par in terms of customer satisfaction. Nevertheless, a significant proportion of those complainants that respond to our surveys are dissatisfied with aspects of our service (see below). We will seek to improve upon 'being on a par'.

Complainant Satisfaction Survey

As part of a three year contract Opinion Research Services (ORS) has been undertaking half yearly complainant satisfaction surveys on the Ombudsman's behalf. Accordingly, two such surveys were conducted during 2008/9.

Complainants are asked to put out of their mind the outcome of their complaint when evaluating aspects of the service such as courtesy of staff, the ease of understanding correspondence from my office, and whether my office had done what it had promised to do. This is a difficult thing to ask of complainants, and it is evident that those whose complaints had been upheld tended to have a markedly more favourable view of all aspects of the service than those whose complaints had not (or, indeed, those complainants whose complaints had not been investigated because, for example, their complaint was out of jurisdiction or premature).

The results of the year's surveys are similar to those of the previous year. There is a very positive response in relation to courtesy of staff and the use of plain English, however, there is a greater degree of dissatisfaction that my office did not 'do what was promised'. In previous years, it was unclear as to why there is a greater degree of dissatisfaction in this regard. However, the past two surveys invited complainants to explain what it was they thought the Ombudsman had not done. From the responses received to this the most common type of response was that:

- there was a bias in favour of the public body
- there was a failure to investigate
- the investigation was not thorough.

It has emerged that complainants often misunderstand the role of the Ombudsman (for example, expecting the Ombudsman to be an advocate on their behalf), and that others have unrealistic expectations of what the Ombudsman can achieve for them. Addressing these issues are, therefore, an important part of the 'Managing Expectations' project.

Human Resources

I would not be able to fulfil my function as Ombudsman if it was not for my staff. I have been very fortunate in inheriting a committed and expert workforce. It is important however, that provision is made to enable continual development and work has commenced on reviewing our existing staff appraisal and training processes and provision. This will feed in to the work we are currently undertaking in preparation of our aim of being recognised as Investors in People.

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

The current organisation structure of my office is shown at the end of this section.

Internal Communication

Internal communication received attention during the year and following staff consultation an internal communication strategy was produced. As a result, a true intranet system was introduced into the office for the first time. This provides a one stop shop for all of the key documents and processes that staff need in their work. It includes news and views and is the place to find the internal newsletter 'The Magnifying Glass' which was also introduced this year This new intranet will be a growing resource for us. In addition, a comprehensive briefing system has been developed to improve communications between teams.

Learning from Other Ombudsmen

The year 2009 is an important and notable one in the world of Ombudsmen for it marks two hundred years since the establishment of the first Ombudsman scheme (in Sweden). The role of an Ombudsman is unique, and although no two Ombudsman schemes are exactly alike, being able to learn from each other is important, be that at international, European or UK level.

Members of my staff have over the past year benefited from discussions with their counterparts at British & Irish Ombudsman Association (BIOA) meetings. These have been valuable opportunities to exchange examples of good practice and to share and discuss issues of mutual concern. Furthermore, I was pleased that we were able to host two BIOA interest group meetings at our offices in Pencoed in March. I am particularly pleased that the BIOA Annual Conference will be held in Cardiff in 2010.

In addition, my staff and I made a number of visits to colleague public sector Ombudsman offices throughout Great Britain and Northern Ireland as part of our research for the Managing Expectations project. I would like to thank colleague Ombudsmen and their staff for spending their valuable time in explaining their approaches to, and experiences in, complaint handling to us and for making us so welcome.

Complaints about the PSOW Service

It would be incongruous of me to expect bodies in jurisdiction to have effective complaints handling procedures in place for the services that they provide and not to have such a procedure in place for my service.

The 'Complaints about us' procedure can be used if, for example, a complainant may wish to complain about undue delay in responding to correspondence; or that they feel that a member of staff has been rude or unhelpful; or that we had not done what we said we would. The aim of 'Complaints about us' is to provide a procedure which:

- is an accessible, simple and transparent process for looking into complaints about my service
- responds quickly to complaints; and
- apologises and provides any appropriate redress if a poor service has been given.

However, if a complainant is unhappy with:

- a decision not to investigate their complaint, or
- a decision to discontinue our investigation of their complaint, or
- the outcome of our investigation

then they can use the appeals process and either write to me directly or through the officer dealing with their case. I will consider their appeal personally. Further details about this procedure are available on my website: **www.ombudsman-wales.org.uk**.

Details of the 'complaints about us' received during 2008/09 are as follows:

Total received	**Outcome**			
	Not upheld	Referred to Ombudsman (appeal against case decision)	Upheld	Still open at 31 March
15	9	3	2*	1

*Note:

- The first of these two complaints was in respect of delays in responding to a particular e-mail received from a complainant. A letter of apology, which explained how this situation arose was sent and in addition our processes were reviewed.
- The second of the complaints upheld was in relation to the delay in considering a public body complaint. This was due to the high workload volumes which we were experiencing at the time. A letter of apology was sent and a full explanation on the backlog position was given.

Strategic Plan 2009/10 to 2011/12 (Extract)

Our vision

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

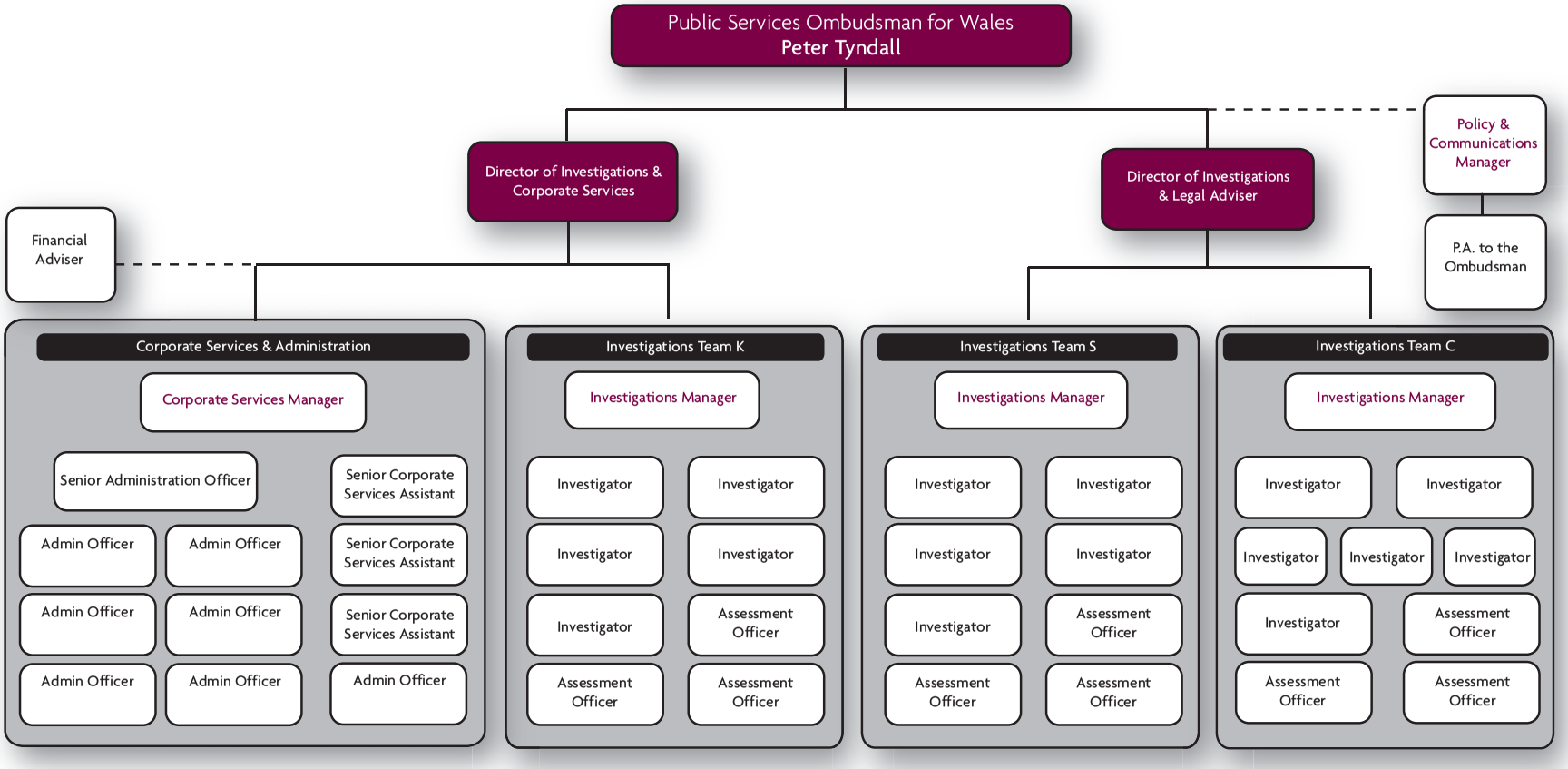
Our values

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

Our Purposes

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

Organisational Chart



Annex A

Public Interest Reports – Case Summaries

Health: Cardiff Local Health Board
(Public Interest Report 200700482 issued May 2008)

Mr R complained to me about the manner in which Cardiff Local Health Board (LHB) had assessed his sister-in-law's eligibility for continuing care. Mr R's representative argued that because his sister-in-law, Mrs P, had unstable, unpredictable and complex healthcare needs and was at risk of unstable blood sugars, she should have been found eligible for NHS funded continuing care (NHSFCC). However whilst the LHB's Continuing Care Manager indicated in her assessment that Mrs P had unpredictable, complex and unstable healthcare needs, the overall decision of the multidisciplinary team who assessed her was that Mrs P did not meet the criteria for NHSFCC. The Continuing Care Manager told Mr R that Mrs P's needs "are not of a nature, complexity, intensity or unpredictability that regular input is required by one or members of the NHS multidisciplinary team.". Mr R also asked the LHB's independent continuing care panel to review the decision but the Panel confirmed that in its view Mrs P's needs were not such that she met the eligibility criteria for NHSFCC. Mr R's representative argued that this decision was flawed and was not in keeping with Welsh Assembly Government guidance and also was not in keeping with relevant legal judgements. When my Professional Adviser considered the complaint he found that the LHB had set out an inappropriate rationale for its decision. The Adviser also considered that the LHB appeared to have focused on the need for interventions, rather than taking a Primary Health Need Approach, as set out in Welsh Assembly Government guidance and legal precedents, as the rationale for its decision that Mrs P is not eligible for NHSFCC. He concluded that the LHB's decision was flawed in that the rationale given for it was incompatible with the Primary Health Need Approach. I concluded that there was no appropriate foundation for the LHB's decision as taken. I found this to be maladministration and upheld the complaint. I recommended that the LHB undertake a full retrospective and current review of Mrs P's eligibility for NHSFCC; review the framework documentation it follows to assess NHSFCC; apologise to Mr R and reimburse him his reasonable legal costs and provide him with additional financial redress for his time and trouble.

Postscript: Cardiff Local Health Board subsequently reviewed Mrs P's entitlement to NHSFCC and found her eligible.

Health: Cardiff and Vale NHS Trust and Cardiff Local Health Board (Public Interest Report 200700617 and 200700636 issued May 2008)

Mrs R complained that she had been told at her local hospital that she would not be offered a routine prophylactic treatment because it was not funded by the Local Health Board. This was despite the fact that she was aware that the treatment in question (routine antenatal anti-D prophylactic injection for pregnant women of a rhesus negative blood group) was recommended by National Institute for Clinical Excellence (NICE) guidance, and that patients in Wales were therefore entitled to receive it.

Mrs R complained to the Local Health Board and applied to it for funding for the treatment on an individual basis; however she said that the funding was not granted in time and she had to pursue the first course of treatment privately at a cost of £100.

The Trust stated that the Local Health Board had not funded it to provide the treatment routinely. It did however administer antenatal anti-D when it was clinically indicated. The Local Health Board said that it had provided the Trust with sufficient funding to cover the cost of the drug, though it was not prepared to agree to the Trust's stated associated staff costs. It said that it had not been aware, prior to Mrs R's complaint, that the Trust had not been implementing the NICE guidance in this case.

I found that both the Trust and the Local Health Board had statutory obligations in respect of service provision and the implementation of the NICE guidance. I said that it was unacceptable for patients to be denied access to a treatment which they should be able to receive on clinical grounds simply because the different NHS bodies responsible could not agree whose budget should bear the cost. It was for the bodies to come to an agreement about funding without compromising the service to the patient. I recommended that the Local Health Board should reimburse the £100 that Mrs R had paid for her private treatment. In addition, she should receive a payment of £250 in recognition of the additional stress caused to her and her time and trouble in pursuing her complaint. I also formally brought the content of the report to the attention of the Welsh Assembly Government's Minister for Health and Social Services.

Postscript: Following on from my letter, the Minister issued a Circular to the NHS in Wales reinforcing guidance that it is unacceptable for funding issues to impact on patient treatment.

Health: Newport Local Health Board (Public Interest Report 200700927 issued June 2008)

Mrs B complained to me that Newport Local Health Board (the LHB) had failed to deal with her appeal against a decision by a Specialist Panel that her Mother, Mrs P, was not eligible for NHS funded continuing care (NHSFCC). Mrs B was particularly aggrieved that the Local Health Board had taken too long to deal with her appeal. She pointed out that even though the LHB's own policy stated that requests for appeals should be presented to the LHB's Independent Review Panel (the Review Panel) in 10 working days, over 12 months had elapsed with no action being taken. Mrs B was also unhappy, that, at the time of complaining to me, the LHB had been unable to provide any indication whatsoever as to when the Review Panel would hear her appeal. She also complained that the LHB had failed to respond to a number of her letters.

The investigation found that the LHB had failed to deal with Mrs B's request for an appeal in a timely manner and identified a number of periods where the LHB was apparently taking no action to progress Mrs B's appeal. Furthermore by the time Mrs B finally had her appeal heard by the Review Panel, over 19 months had elapsed. The investigation also identified a significant number of other individuals whose appeals to the Review Panel were being delayed unreasonably. The investigation also found that the LHB had failed to respond appropriately to Mrs B's correspondence on a number of occasions.

I upheld the complaint and recommended that the LHB apologise to Mrs B and pay her redress of £500 for failing to deal with her appeal in a reasonable manner. I also recommended that the LHB deal with other outstanding appeals to the Review Panel urgently and also made recommendations relating to the manner in which the LHB dealt with requests for appeals in future. The LHB agreed to apologise to Mrs B and to pay her the recommended redress.

Health: Conwy Local Health Board (Public Interest Report 200701836 issued September 2008)

Ms Y complained on behalf of Mrs X that Conwy Local Health Board ("the LHB") allowed Mrs X to pay top up fees to the nursing home that Mr X moved into after he was deemed eligible for full NHS continuing care. She said this was illegal as the LHB had an obligation to meet all of the fees for accommodation and care. Ms Y stated that that the LHB's decision cost Mrs X about £44 each week from October 2006 until January 2008.

The evidence showed that the LHB had made commissioning plans for Mr X to be placed in a particular nursing home. That home charged the standard rate that the LHB was willing to pay for continuing care patients. However, Mrs X found an alternative home for Mr X that she considered more appropriate to meet his needs. She made arrangements for Mr X to be moved to the home of choice by liaising with the NHS hospital in which Mr X was a patient at the time. When the LHB found out about this, it commissioned the placement but on the basis that Mrs X could and would meet the additional cost over and above its standard rate. It then restricted its payments to the standard rate. Mrs X made the top up payments directly to the nursing home in which Mr X resided.

I concluded that the law and relevant guidance did not allow the LHB to require Mrs X to meet the shortfall. The full cost of accommodation and care should be met by the LHB in cases where continuing care eligibility has been established, as these patients are the responsibility of the NHS. I found that the LHB could have refused to sanction the placement or tried to negotiate a lower fee. Failing those options, it should have met the full fee. I found that it was maladministrative not so to do. As Mrs X had met the additional costs involved when she should not have been required to do so I upheld the complaint. In recognition of this, I recommended that the LHB repay the fees incurred to Mrs X. I also asked the LHB to inform me of any other patients who had been, or were, in a similar position to Mr X and the total figure of top–up fees paid by those patients or their families. I requested that the LHB inform me about its intentions regarding these people.

Postscript: The Local Health Board has now informed me that it has taken steps to identify and reimburse other individuals who were similarly affected.

Health: Ceredigion LHB and Ceredigion and Mid Wales NHS Trust (Public Interest Report 200700788 & 200701470 issued January 2009)

Mr Y, who suffered a spinal cord injury in a road accident in the mid 1990s, complained that the former Ceredigion & Mid Wales NHS Trust (now replaced by Hywel Dda NHS Trust) and Ceredigion Local Health Board were responsible for unacceptable delays in implementing NHS funded home care packages since 2003, and that as a result, he had been forced to pay for the care himself. He also complained that there was an unacceptable delay in providing him with a profiling bed, and that the attitude of some of the staff involved in his care was unacceptable.

I found that the LHB had considered each application for funding in a timely manner, and was not therefore critical of its actions in relation to the starting of the care packages. Turning to the actions of the Trust, I found that there was an unacceptable delay in implementing the care package from February to December 2003 which was caused by a failure to make adequate cover arrangements for the absence on maternity leave of Mr Y's nominated care co-ordinator. I recommended that the Trust reimburse Mr Y for the cost of his care in this period.

While efforts were made from that point to arrange a care package, it did not start until February 2006. I found that the Trust was not entirely responsible for this delay, which was partly down to the complicated nature of the care package, where some elements were being funded by the NHS, and others by Mr Y through direct payments received from the local authority and the Independent Living Fund. These two elements operate to different rules; while direct payments allow service users a great deal of freedom to arrange their care how they wish, that is not the case with NHS funding (which cannot be made in the form of direct payments). This caused some difficulties as, at least initially, Mr Y was unwilling to accept the various statutory and procedural requirements that needed to be met before the package could begin. However, I also found that it was not always clear from the Trust's records what (if anything) was happening for not inconsiderable periods of time. On the other hand, the notes did also suggest that on occasions Mr Y did not return calls or release his staff for training. I therefore only partly upheld this part of the complaint.

In June 2007, Mr Y indicated that he wanted to change the agency which had been providing his care package, on the grounds that it had not provided cover for staff absences, or adequate staff training. Mr Y said he had raised concerns previously about the agency, but this was denied by the NHS staff involved, and there is no record on file of his doing so before that time. Mr Y was informed by the LHB that while it was willing to fund his care through another agency, this could not happen until his new staff had undergone the required training, assessment, and criminal records checks. While this unfortunately meant that Mr Y had to pay for his own care for a time, I found that there was no evidence of maladministration or service failure on the part of the NHS organisations involved, which had made clear to Mr Y the implications of terminating the existing care package before alternative arrangements were put in place. I did not uphold this part of the complaint.

Turning to Mr Y's complaint about delays in obtaining a profiling bed, I was critical of the fact that it took around seven months for an occupational therapy assessment of Mr Y's needs to be carried out and

reported on. While the occupational therapist was employed by the local authority, the responsibility for providing a timely assessment remained with the NHS, and I therefore upheld this part of the complaint and recommended that Mr Y be paid £100 in recognition of the delay. I noted that staff interviewed as part of the investigation had acknowledged that there were often delays in obtaining occupational therapy assessments in the County. I therefore also recommended that efforts continue to be made to try to resolve this problem.

Finally, Mr Y complained about the attitude of NHS staff, some of whom he considered rude and dismissive. While it was noted that relations between Mr Y and the staff involved were not always smooth, I could not find evidence to support Mr Y's assertion that their behaviour was unacceptable. This part of the complaint was not upheld.

Health: Pembrokeshire & Derwen NHS Trust & Pembrokeshire Local Health Board (Public Interest Report 200702138 and 200702139 issued February 2009)

Mrs T, a lady who suffered from diabetes and an irregular heartbeat, had previously lived independently. She suffered a severe stroke in January 2006 as a result of which she was left with a number of problems and was totally dependent on others for her needs. Mrs T could not swallow or speak, and she was immobile and incontinent. She sadly passed away during the investigation (in March 2008).

Mrs T was discharged from hospital to her daughter's home; Mrs G the complainant. Prior to discharge a specialist Nurse had submitted a limited application for Continuing Health Care Funding to the Local Health Board for equipment only; a special mattress, bed and hoist to assist in caring for Mrs T. Carers (provided through the Council's Social Services Department) attended daily to help Mrs G with her mother's needs, for which Mrs T was liable to pay. District Nurses otherwise attended to deal with the monitoring and treatment of her diabetes and heart condition. Further applications for full CHC Funding were made, at Mrs G's request, to meet her mother's considerable needs all of which were declined until the existing documentation was considered by a team from a neighbouring LHB in January 2008 who concluded that Mrs T satisfied the eligibility criteria for fully funded care, and had probably done so from the very outset.

My investigation reviewed all the documentation, which was also considered by one of my independent professional advisers. Numerous failings were discovered on the part of both the Trust and the LHB in dealing with Mrs T's case representing a series of errors, poor administrative practices and a breach of professional standards. These included: no proper assessment of Mrs T's needs against the CHC Funding criteria was undertaken at the outset before she was discharged from hospital - despite the combination of needs being sufficient to trigger such an assessment - resulting in a limited initial application for equipment; communication failings with Mrs G such that she was either asked for information already known or repeatedly asked for consent forms or power of attorney documents for her mother (who was in no position herself to now grant such) in order to later proceed with review requests for CHC Funding; the inevitable delays and frustration caused to Mrs G as a result of such requests and communication

issues; poor record keeping on the part of the LHB in that CHC Funding panels were not minuted and no clear record of the reasons for decisions kept – a systemic failure at the relevant time; and a breach of the professional standards for nursing record keeping by the Trust's District Nursing Team such that year old documents (then undated) were re-used, whilst purporting to represent the current and up to date needs of Mrs T, upon which the funding decisions were based (the originals being subsequently re-dated, after the event, prior to their submission to me as part of my investigation).

As a result of the catalogue of failings uncovered by my investigation, both the Trust and the LHB put in place procedures to avoid a recurrence of some of the failures identified. I otherwise made a number of recommendations including that both the Trust and the LHB should offer a suitably worded written apology to Mrs G for the failures identified as well as financial redress of £1000 (to be apportioned equally between both bodies) in recognition of the injustice and distress she had suffered; the LHB should expeditiously complete the retrospective review of Mrs T's CHC Funding eligibility (back to the time of her discharge from hospital) and, if she was entitled, refund to her estate all monies already paid for the care provided to her by Social Services; and that the LHB should review its current arrangements for requiring consent or capacity forms. I further asked that Trust staff be reminded of the formality of my investigation and the evidence that is considered during it.

Health: Torfaen Local Health Board, Torfaen County Borough Council & Gwent Healthcare NHS Trust (Public Interest Report 200701931, 200701932 & 200802681 issued February 2009)

Transition from school - lack of understanding of the NHS continuing care decision making process, no comprehensive assessment of needs – delay in arranging suitable provision.

Mr and Mrs T complained of delay by the health authority in providing appropriate provision for their son, John when he left school. They said that there had also been ineffective transition planning by the Council which had contributed to the delay and a general lack of co-operation between the bodies concerned.

What happened

John is autistic with learning disabilities and extreme challenging behaviour. John's need for an appropriate placement with 2:1 support was identified in his transition plan at age 14. After a period of being excluded from school because of his behaviour John was placed in another special school at age 15 with his own classroom, a teacher and teaching support. The Council's transition co-ordinator confirmed that John would require specialist services on leaving school due to his complex needs and later identified a specialist centre for autism as suitable for John. This was not progressed as part of the long term plan for John and no placement was available when John reached 18 in June 2006 and John stayed at his special school until age 19. He was without full time day care since then and without respite care since June 2006, with the exception of some holiday provision during the summers of 2006 and 2007. In the meantime Mr and Mrs T had 24 hour care of John.

On 24 January 2006, the Trust wrote to the Council saying that John might be eligible for continuing care funding for any future day support services.

John was confirmed as eligible for continuing healthcare in October 2006. The Trust started the process of developing a day service for John which could also be used for respite purposes. This involved adaptations to a room in a Council day centre. Following discussions with the LHB the service proposal for John was developed to provide a service model which could be developed to meet the needs of other service users in the County. On 28th February 2008 when the service was still not in place Mr and Mrs T complained to the Trust about the continued delay in the provision of any service. A very limited service was in place from September 2008 but was suspended by Mr and Mrs T because of a lack of a pad changing regime for John. The service was reintroduced following the issue of a draft of this report and had gradually increased throughout January 2009 to 5 daily sessions. When this report was issued John was in receipt of half of his assessed day provision with no respite.

My View

I found that there was a lack of transition planning and of effective co-operation between the bodies concerned which resulted in delay in providing the appropriate service for John.

I took into account the Council's acknowledgement that John's transition was not well co-ordinated. A possible placement had not been pursued at the time when it should have been and there was a lack of any concerted effort to put together a service for John when this was still the Council's responsibility. I found that there was a lack of focus and forward planning at a sufficiently early stage. I concluded that this undoubtedly impacted on the overall time taken to locate day care. I was also concerned that the Council had failed to refer a request made by Mr and Mrs T for the assessment of John for continuing healthcare to the health authority or to give the appropriate advice.

I commented that there was little clarity of roles and responsibilities and no well defined structure for co-operation between agencies during John's transition phase. There was also apparent confusion over which body was responsible for taking the lead on John's placement and who would be responsible financially even after October 2006 when John was eligible for continuing care and the responsibility clearly lay with the health service. In my view because of the failures of the agencies involved, John's transition to adulthood was anything but smooth and seamless.

I questioned why the health bodies had not carried out an assessment of John's entitlement to continuing health care funding sooner, given that he was known to health professionals in the Trust and it was acknowledged that there had been no apparent change in John's medical condition. I was critical that there was a fundamental lack of a proper continuing care process throughout this case. I considered that the continuing care eligibility decision should have been taken much sooner than it was, with clear agreement between health and social services on how John's package of care would be planned, co-ordinated and provided. Significantly, I highlighted that there was no comprehensive unified assessment of John's needs followed by appropriate needs-led care planning with the appropriate service design and commissioning running alongside. The lack of such an assessment at the outset, particularly in respect of John's physical needs, meant that there were problems later in delivering the service. I also found that there was a protracted and fragmented approach for the approval of costings of the various elements of the service.

I commented that there had been changes in commissioning arrangements between the Trust and the LHB but that the LHB ultimately had responsibility for ensuring that John's service was delivered. I identified that there was a failure by both health bodies to engage constructively and with a sense of urgency to ensure that the service was provided. I acknowledged that to the health bodies' credit that John was not offered an 'off the shelf' service which would have been inappropriate given his special needs and that a 'bespoke' service was designed and then developed to enable it to be implemented across the County. I said however, that the service should have been in place much sooner. I concluded that the LHB should have played a much more proactive role as commissioner of the service. Instead there was an absence of active monitoring and firm intervention.

Outcome

The bodies agreed to apologise to Mr and Mrs T and to place in trust for John the sum of £25,000 (£20,000 from the LHB and £5,000 from the Council). They also accepted my recommendations, including those in respect of a more robust transition policy, appropriate staff training to improve understanding of the continuing care decision making process, with the emphasis on the importance of comprehensive needs-led assessments and measures to improve inter agency co-operation.

Lack of Guidance

My findings highlighted the impact of the lack of guidance regarding the arrangements for continuing healthcare for children. I asked the Welsh Assembly Government to ensure that guidance was introduced as quickly as possible.

Housing: Cardiff County Council
(Public Interest Report 200600749 issued April 2008)

Mr F and his pregnant wife had been living in private accommodation since arriving in Cardiff and had applied for housing; they were registered on the waiting list in line with the Council's pointing scheme. They became concerned when the building his flat was in was sold and the new landlord served notice to terminate his assured shorthold tenancy. The landlord advised him that he regarded the properties as below habitable standard and was starting an extensive programme of renovation in the near future.

Mr F went to the Council who said that the notice was defective and that he should remain in situ. They contacted the landlord to advise that the notice was defective and asked him to fill in a form to explain why he was seeking to evict Mr F.

Mr F's wife then gave birth to a son who had medical problems and was being disturbed by the building work. Mr F revisited the Council on several occasions over the coming weeks but was only given advice rather than consideration under prevailing legislation as a potentially homeless person. He went to a Law Centre and a solicitor wrote three letters to the Council asking for Mr F to be housed and also rang the case workers on several occasions outlining the family's situation.

There was no home visit to assess the impact of the building work on the family nor were enquiries made as to their medical situation, neither had Mr F been given a decision letter following his requests to be housed. Mr and Mrs F found this an extremely stressful time and Mr F had been planning to work to help fund his tertiary education but was unable to do so as his wife needed support at home and he was visiting his solicitor and the Council regularly. The Council did not formally commence enquiries as required by the legislation until some five months after his first presentation for help.

The Council initially acknowledged some failings in its handling of Mr F's case but did not accept that he had been disadvantaged in terms of obtaining permanent accommodation. It said it had a consultancy in place to review this area of operation and was open to suggestions that would improve its procedures.

I found that there had been undue delay in addressing Mr F's housing problem and that there was a failure to carry out enquiries as to his home circumstances which could have led to his being accepted as homeless or threatened with homelessness at an earlier stage. As a person in priority need he could have been offered temporary accommodation while the Council conducted its statutory enquiries.

I recommended that the Council should apologise to Mr F and pay him £1,500 in recognition of the delay and difficulties he had faced. I further recommended that the Council should, as it intends, introduce improved procedural guidance and training for its staff; and that it should consider the provision of staff to undertake home visits to those who are homeless at home or threatened with homelessness.

Housing: Isle of Anglesey County Council
(Public Interest Report 200700225 and 200700708 issued August 2008)

Mrs James complained about the Council's handling of her housing benefit claims from November 2006, saying that she had been on a low income and in intermittent employment. She said that she had experienced numerous communication difficulties with the Council and failings on its part to make decisions promptly in line with the Housing Benefit Regulations to consider and make interim payments when requested to do so. It had failed to respond when she had sought to use the formal complaint procedure of the Council. She said that these failings had placed her both in stress and in debt and that she had had to spend a great deal of time resolving these matters with the Council which had taken over a year to finalise.

Mr Davies said that he had moved from a private tenancy to a Council tenancy in July 2006 and had since October 2006 been pursuing a claim for Housing Benefit to cover an unavoidable dual rent liability. He said that he had failed to get answers to his correspondence and had made a formal complaint without response. He had requested reviews of the position but the Council was failing to apply the correct Housing Benefit Regulations to his case.

My investigation found numerous and severe administrative failings within the Housing Benefit service of the Isle of Anglesey Council including an absence of accurate housing benefit performance information, failure to report accurate information to regulatory bodies in Wales, failure to implement internal procedures with regard to complaint and post handling and extensive and repeated failures to abide by statutory targets in the Housing Benefit Regulations in respect of the two complainants' claims.

Accordingly, I upheld the complaints and recommended that the Council take urgent action as already recommended by regulatory bodies to improve its housing benefit performance through training, improved systems and communication between staff. I further recommended that it made an apology to both complainants and a payment in the sum of £1,500 to each in recognition of the difficulties they had experienced.

Housing: Conwy County Borough Council
(Public Interest Report 200702044 issued December 2008)

Ms I & Mr W were, at the time events took place, private rented sector tenants living in an upper floor flat (referred to as 1 Red Street in the report) with their young daughter. As a result of the rent becoming increasingly unaffordable since Ms I had left employment, they applied to the Council for accommodation. The Council's Enforcement Team inspected 1 Red Street and had concerns about the lack of adequate fire safety precautions and concluded that works were required. A notice requiring certain works was served on the owner who, in turn, served a notice to quit on Ms I & Mr W. It was also claimed by Ms I & Mr W that their landlady's husband, Mr X, attended the flat threatening them and that he assaulted Mr W. They complained that the Council did not do enough to assist them and that they were offered unsuitable temporary accommodation at the last minute, and so had to stay with friends

and family until they were eventually offered a Council tenancy. They also complained about the cost charged to them by the Council in dealing with the removal and storage of their belongings when they had to leave their flat and that the Council's contact with their landlady had resulted in them being served with a notice to quit.

My investigation found that there was sufficient evidence to suggest that the threshold for conducting homelessness inquiries into Ms I & Mr W's circumstances had been breached and merited investigation at an earlier point than those inquires were actually commenced by the Council's Housing Options and Support Team ("HOST") . Had the Council acted as the law intended Ms I & Mr W would have been entitled to an earlier offer of temporary accommodation and a decision on their homelessness status much sooner. The decision itself, when made, was issued outside the maximum time limit contained within government guidance and the Council's own written procedures. Despite the concern expressed about the Council's failure to recognise when homelessness inquiries should begin, I found that its charge for recovering the cost of removing and storing Ms I & Mr W's belongings was reasonable. I also found that the Council's action in issuing the landlady with a notice to perform works at the flat was entirely appropriate and that it could not have accurately predicted that it would result in the landlady serving a notice to quit upon them. Given the change in the Council's housing allocations policy it was not possible either to know with any degree of certainty whether Ms I & Mr W would have received an offer of permanent accommodation any sooner than they did. Since the investigation was concluded the Council had transferred its housing stock.

I recommended that the Council apologise to Ms I & Mr W for its failings and offer them redress in the sum of £500; implements a training programme for all homelessness staff on the recognition of homelessness and identification of when inquiries should begin; and reviews and rewrites as appropriate its written procedures for HOST staff. I also expressed a wish for the new social landlord to consider ensuring its staff also underwent training on homelessness issues in order to promote good working relationships with the Council's homelessness section.

Housing: Conwy County Borough Council (Public Interest Report 200701993 issued January 2009)

Mr and Mrs Smith are tenants of Clwyd Alyn Housing Association. Mr Smith is disabled with multiple health problems and Mrs Smith's first language is neither English nor Welsh. They have a young son.

In 2003 the Smiths moved in to a Clwyd Alyn property that was next door to a family who were tenants of Conwy Council. They complained that they were subject to noise and disturbance from various members of the family and that they gradually became subject to direct intimidation, abuse and racial harassment which intensified after they gave evidence in court proceedings against the family. They said that this behaviour continued and that they made regular complaints about the behaviour of the family to Conwy County Borough Council.

They said that they had never been advised of the procedures that the Council had in place for dealing with anti social behaviour and that the Council had not communicated with them adequately over their complaints or properly investigated or acted upon the family's behavioural problems and repeated breaches of their conditions of tenancy.

During the course of the investigation, information was obtained from the complainants, the Council, North Wales Police and Clwyd Alyn Housing Association regarding the Smiths' complaints and the responses of the relevant agencies.

I reviewed five previous public interest reports that had been issued on Conwy County Borough Council's previous handling of complaints involving racist abuse, anti social behaviour and its failure to consider the position of victims of anti social behaviour in relation to the Human Rights Act 1988 and Homelessness Act 2002. The first of these reports was issued in September 2005 and the last in February 2008 under Section 21 of the Act which also upheld a complaint over Conwy County Borough Council's failure to properly administer complaints of anti social behaviour, making a total of six reports.

Whilst acknowledging that some administrative changes had been made by the Council as a result of these reports, I was concerned to find in the Smiths' complaint evidence of replication of previous failings to deal with anti social behaviour long after the compliance period for implementation of recommendations in the earlier reports, most notably after the establishment of an anti social behaviour unit and after the Council said it had provided additional training for staff.

I found a continuing lack of knowledge on the part of Council staff in dealing with enforcement action, particularly in relation to demoted tenancies, also failure to administer procedures which the Council had put in place or to communicate with Mr and Mrs Smith in an appropriate manner. I also commented on the continuing over reliance of the Council on the input and expertise of North Wales Police officers, who were the main catalysts for moving the case forward. Evidence the police provided to the Council of the criminality of the family was not acted upon in a timely or adequate manner. In marked contrast, the joint working between North Wales Police and Clwyd Alyn Housing Association was exemplary. Legal action taken by Clwyd Alyn in the absence of any meaningful action by the Council was prompt and effective and based on the same body of evidence that was available to the Council.

I recommended that the Council pay the Smiths the sum of £2,500 for each of the four years during which I considered the main aspects of maladministration and injustice to have occurred and recommended that a fulsome and detailed apology should be provided to them from the corporate level of the Council.

I also recommended that the Council ensures that its staff and those exercising functions on its behalf conduct a further review of procedures for dealing with homelessness and anti social behaviour and provide additional training and procedures to remedy the shortcomings identified in this report and for evidence of this to be provided to me within three months of the date of the report.

I considered that as the impact of events upon the Smiths had been so profound and that because there was a lengthy history of failing to administer these areas of work adequately, despite numerous previous

and agreed public interest reports on the topics, that it was in the public interest to issue another report under Section 16 of the Act with a request that it be placed before full cabinet by the Council in order to maintain the profile of these issues within the Council at a time of administrative change.

Housing: Gwynedd Council
(Public Interest Report 200800969 issued February 2009)

Mrs R was a tenant of a two bedroom Housing Association property and had applied to the Council for accommodation as the family needed a larger home. Living with Mrs R at the time of her initial application were her husband, and three children. In addition a step son periodically stayed with the family and this arrangement had become more permanent in later years. The family had by the time of this investigation been on the Council's housing waiting list for almost ten years. Within that time the Council's housing policy had been revised twice, most recently in 2007. In addition to citing the cramped conditions within her home Mrs R had written to various officers within the Council's housing section on many occasions, querying her position on the waiting list and why she did not fare better in line with the Council's policy. The overcrowding was affecting her and her husband's health and the family had a number of reasons for wanting to stay within the locality. By February 2005, the conditions had become so intolerable at the property that one of Mrs R's sons had to go to sleep every night at his grandparents who were themselves in poor health and relied on Mrs R's proximity for daily support.

My investigation found that there was sufficient evidence to suggest that the threshold for conducting homelessness inquiries into Mrs R's housing circumstances had been breached and merited investigation from the housing application form and supporting evidence submitted by Mrs R. Specifically, by February 2005, it was possible to say that it was no longer reasonable for the family to continue occupying the property and they were, in law, homeless. This meant that the Council's more extensive duties would be engaged as well as an expectation of an increase in the level of points awarded to Mrs R's application in line with the Council's policy. The family could also have been assessed as "homeless at home". The Council failed to recognise that the level of overcrowding and the family separation merited investigation. Neither had it adduced any evidence which might show that Mrs R's circumstances were no worse than other families on the Council's housing waiting list. These failures amounted to maladministration.

In light of my finding in earlier investigations that the Council's housing allocation policy (before its radical revision in 2007) was unlawful, it was not possible with any degree of certainty to know whether Mrs R would have received an offer of permanent accommodation acceptable to her sooner. Given evidence of housing offers made within the same period to applicants Mrs R would have at least equalled their points total but, without a review of all those applications in some detail, it would be impossible to know whether they would also have benefitted from increased awards themselves if assessed in line with a lawful policy. On balance, it was highly probable given the length of time Mrs R had been on the list, that she would have received an earlier allocation. In light of that I recommended

that as well as apologising to Mrs R and her family for its failures, the Council should offer them redress in the sum of £2500; it should offer her the next suitable and available 3 bedroom property in her selected area; it should implement within 3 months a training programme for all frontline housing staff (and Senior Managers) on the recognition of homelessness and when enquires should begin; and that a Senior Officer in the Council's housing section should thereafter undertake a review of all applicants on the housing waiting list (with homelessness issues in mind) to ascertain whether those applicants had been properly assessed. Details of that review, to be completed within 9 months of the report's issue, should be provided to me.

Planning: Gwynedd Council (Public Interest Report 200601953 issued June 2008)

Mrs P complained to me about the manner in which the Council failed to take action to enforce a condition it imposed on a planning consent it had granted in January 2004. The planning consent was granted for the retrospective approval of the construction of a cottage and associated access track. The condition in question was attached to ensure that the developer submitted for approval, and subsequently implemented, plans to ensure that there was appropriate drainage in place in relation to the newly constructed access track. Mrs P pointed out that the condition had been imposed because the track that the developer had constructed had caused surface water to flood onto an access lane she utilised which was also a public right of way. The damage to the lane not only damaged the surface of the lane but also eventually caused its collapse which Mrs P had had to rectify at her own expense. Mrs P complained to the Council about its failure, over two years after the condition was imposed, to take enforcement action in relation to the developer's failure to install appropriate drainage. Her complaint was heard by the Council's complaints committee who determined that the Council had acted appropriately in relation to the manner it had handled the matter. Mrs P remained dissatisfied and complained to me in February 2007 about the Council's failure to take enforcement action in relation to the developer's failure to comply with the condition imposed on the planning consent.

The investigation found that the Council had failed to act in a timely manner in relation to a potential breach of planning consent of which it was aware. Furthermore the investigation also found that the Council had failed to demonstrate that it had considered the expediency, or otherwise, of taking enforcement action against the developer. Furthermore the investigation also found that the Council had failed to make good its commitment to Mrs P that unless the owner complied with the condition "the department will take the necessary enforcement action". The investigation also considered the manner in which the Council's complaints committee dealt with Mrs P's complaint. The manner in which the Committee had considered Mrs P's complaint may have led her to have concern. However it is evident from a review of a recording of the complaints committee's meeting that Mrs P's complaint was given appropriate consideration.

That said, I found that the Council acted unreasonably in the manner it had handled the enforcement issues about which Mrs P complained. I also found that this maladministration led to a personal injustice

to Mrs P and accordingly upheld the complaint. I did not uphold Mrs P's complaint in relation the manner in which the complaints committee dealt with her complaint to it under its complaint procedure.

I recommended that the Council should apologise to Mrs P and provide her with redress of £2000 for the failings identified in the report. I also recommended that the Council's Planning Department should make certain changes to the manner in which they handled enforcement issues.

Social Services: City and County of Swansea (Public Interest Report 200601103 issued July 2008)

Mr & Mrs J are Council tenants and complained, through their solicitor, that the Council had not carried out adaptation work to their home at 2 Green Street as required in light of Mrs J's health problems. She had suffered a stroke in 2000 and had been unable to properly use the bath since and needed her son to lift her in and out. Neither, alternatively, had the Council offered Mr & Mrs J anywhere else suitable to live even though it wanted them to leave their home as it had development plans for the area. The solicitor complained too that her formal letter of complaint about these issues had gone unanswered by the Council.

I found that whilst the Council had, through its Occupational Therapist (OT), assessed a need to adapt Mr & Mrs J's bathroom including installing a shower, that this need had not been met. My Professional Adviser visited 2 Green Street and confirmed that in his opinion the bathroom was capable of being adapted to meet the needs of Mrs J. The Council had intended to seek possession of Mr & Mrs J's tenancy (proceedings that had to practical effect been concluded in 2004 but were resurrected once more by the time the investigation was concluded). One department at the Council had indicated when proceedings were originally envisaged that adaptation works could not be agreed to. The assessed needs therefore went unmet with Mrs J still being unable to properly bathe. There was no evidence that Mrs J's case had been reviewed or monitored for the provision of any necessary services or help by way of alternative in the absence of adaptation. It was my finding that failing to meet an assessed need was maladministration.

Whilst there was evidence that the Council had made some offers of alternative accommodation to Mr & Mrs J, some had materialised only during the course of the investigation. Mr & Mrs J had however felt unable to accept them although one offer, in an area for which Mr & Mrs J were registered, remained pending at the time the investigation was concluded. I was satisfied that the Council was doing all it could to identify suitable properties capable of adaptation in Mr & Mrs J's preferred areas of choice to offer them. It was treating them as a special case outside its usual housing allocations scheme and Mr & Mrs J needed to engage with the Council in order to resolve their housing issue.

The investigation also found that the formal complaint made had not been answered or dealt with as it should have been but had, rather, passed between individuals none of whom appeared to have taken responsibility for answering it. That also amounted to maladministration.

I recommended that the Council apologise to Mr & Mrs J, within one month, for the failings identified and the distress caused to them by their circumstances and offer them redress in the sum of £3000. The Council should also apologise to the solicitor for the failure to respond to the letter of complaint. It was also recommended that the Council either adapt Mr & Mrs J's home as required or continue in its efforts to re-house them whilst ensuring that immediate interim measures be taken to enable Mrs J to use her bath. The Council should also meet the family's reasonable relocation costs at the material time. In addition the Council was required, within 3 months, to provide evidence of its case monitoring / review procedure in the OT section as well as provide evidence of any protocol / guidance introduced for that team on how to deal with cases where another department had refused its consent to carry out adaptation works that the OT section had assessed as necessary.

Social Services: Vale of Glamorgan Council (Public Interest Report 200700991 issued October 2008)

The complaint is made on behalf of Ian, a man with learning difficulties who had been receiving services provided by Social Services at a number of different day centres. Following two incidents in August 2005, the manager of the day services suspended Ian from all the Centres.

A POVA Strategy Meeting took place to consider one of these incidents, in which, Ian alleged, Officer B had pushed him. I found maladministration and impropriety in the POVA documentation. I also found that Ian's allegation had not been properly investigated under POVA procedures, that prejudicial evidence given by Officer A to the Strategy Meeting was not supported by any available evidence, and that the meeting had failed to reach a robust conclusion on the basis of impartial evidence. I found that these failings amounted to maladministration.

Ian's father made a complaint to a senior manager. I found that the statutory Social Services complaint procedure had not been applied. The complaint was investigated by the senior manager to whom the centre staff reported. Some days later the officer whom Ian had accused of pushing him alleged to the same senior manager that Ian's mother had assaulted her. Officer B's account of the alleged incident was unsupported by objective evidence but recorded as fact on the Council's records and officers' assertions that the Police had been involved were not confirmed by the Police. I found that in his investigation of, and response to, the complaint and the officer's allegation, the senior manager had failed to distinguish between fact and hearsay, had unquestioningly accepted as fact matters for which there was no, or contradictory, evidence and had failed to give Ian's father an opportunity to comment on his findings. The manager refused to reinstate Ian to any day centres and he ceased to receive day services.

The reason for Ian's continued exclusion from services was unclear but based largely on an alleged risk from his family, which I found was based on hearsay and was unjustified. I found that risk assessments compiled by the senior manager were unrealistic.

Ian's father's request that his complaint to be considered at Stage III of the statutory complaint procedure was initially refused. He therefore complained to me at the time. Following my intervention

the complaint was referred to the Independent Complaints Secretariat who found that Stage II of the procedure had not been adequately completed and recommended that the complaint be investigated by an independent investigator. Following completion of the independent investigation the authority arranged a new assessment of Ian's needs which concluded in March 2007 that a protocol for working with Ian's family should be developed and that he should be reinstated to a day centre, Centre Two, immediately. He was not, however, reinstated.

Ian's father requested again that his complaint be taken to Stage III of the complaint procedure. The Independent Complaints Secretariat Review Panel recommended in June 2007 that the authority state clearly whether it was prepared to offer Ian a place at Centre Two. Ian's father received no communication from the authority in respect of the Panel recommendations and complained again to me in July 2007.

Despite successive undertakings given to me, and despite meetings and correspondence between Ian's family and the authority, the authority still failed to reinstate Ian, apparently at least partly because of opposition from two officers. I therefore reopened the investigation into the complaint. Ian was eventually reinstated to Centre Two in March 2008, having been denied access to services which had been assessed as meeting his needs for over two and a half years.

To remedy the injustice caused to Ian and his family I recommended that:

- the Council put in place staffing and other arrangements to ensure that Ian's continued attendance at Centre Two for at least three days a week on a permanent basis so long as it met Ian's assessed needs;
- that a further full apology be made to Ian and to his family;
- that arrangements be made to enable Ian to attend day services without contact with Officer A or Officer B;
- that the Council work towards re-establishing cordial relations between Ian's family and the service;
- that a payment of £3,000 be made to Ian, and a further £1,000 to his parents, in recognition of the fact that the entire task of daily caring for Ian from August 2005 to March 2008, for which Social Services had responsibility, has devolved on the family members;
- that the Council address the specific administrative failures identified in the report, and in particular that it review and improve its arrangements for implementation of POVA procedures, risk assessment and management and its operation of the statutory Social Services complaint procedure, and that it ensure that relevant staff receive proper training to enable them to apply the Council's procedures;
- that the Council examine carefully its management arrangements for its day service provision to ensure that decisions affecting service users are taken without bias and on the basis of documented evidence;
- that the Council ensure that its staff understand and apply the difference between fact, hearsay and conjecture in the process of decision making, and
- that the Council ensure that its staff understand the necessity for documenting decisions and the reasons for them, the importance of maintaining proper documentation and the unacceptability of falsifying documents.

The authority has agreed to accept my recommendations.

Annex B

Outcomes of Complaints – Statistical Breakdown by Public Body

COMPLAINTS CONCERNING LOCAL AUTHORITIES
County/County Borough Councils

County/County Borough Council	Out of Jurisdiction	Premature	Investigation Not Merited	Discontinued	Quick Fix/Vol Settlement	S16 Report Upheld – in whole or in part	S16 Report Not upheld	Other Report Upheld - in whole or in part	Other Report Not upheld	Withdrawn	Total Cases Closed
Blaenau Gwent		8	11	6					1		**26**
Bridgend	6	6	19	2				3	1		**37**
Caerphilly	4	5	15	6	2			3	5	4	**44**
Cardiff	10	11	33	19	4	2		13	4	3	**99**
Carmarthenshire	8	17	26	13	2			3	1	2	**72**
Conwy	5	8	13	2	2	2		1	1	2	**36**
Ceredigion	4	11	5	3	1			3	1	1	**29**
Denbighshire	4	5	8	4	2			3	3	2	**31**
Flintshire	5	11	12	2	3			1		1	**35**
Gwynedd	3	12	22	9	6	3		4	1	4	**64**
Isle of Anglesey	1	8	10	10	5	2		1	1		**38**
Merthyr Tydfil	3	3	11	6	2			1			**26**
Monmouthshire	8	8	8	2	1			1			**28**
Neath Port Talbot	3	11	14	4	2			1	1	1	**37**
Newport	4	7	8	6	2		1	3	1		**32**
Pembrokeshire	5	8	18	9	1			5	2	1	**49**
Powys	1	15	27	9	2			3	1	3	**61**
Rhondda Cynon Taf	8	14	16	7	2			1	1	3	**52**
Swansea	9	5	21	6	2	1		3	2	3	**52**
Vale of Glamorgan	6	6	20	8	1	1		3	2	1	**48**
Torfaen	1	6	8	6		1				2	**24**
Wrexham	2	10	6	7	2			2			**29**
TOTAL	**100**	**195**	**331**	**146**	**44**	**12**	**1**	**58**	**29**	**33**	**949**

In addition to the above, I also closed the following cases :

- 23 complaints against National Park Authorities: of which 1 quick fix and 2 upheld 'other' reports in respect of Brecon Beacons National Park Authority
- 10 complaints in respect of Schools Appeals Panels: of which 2 'other' reports upheld in respect of Rhydypenau Primary School Appeals Panel

Community/Town Councils

Community/Town Councils	Out of Jurisdiction	Premature	Investigation Not Merited	Discontinued	Quick Fix/Vol Settlement	S16 Report Upheld – in whole or in part	S16 Report Not upheld	Other Report Upheld - in whole or in part	Other Report Not upheld	Withdrawn	Total Cases Closed
Abergele										1	**1**
Beguildy			2								**2**
Bodorgan								1			**1**
Brecon		1									**1**
Caldicot			1								**1**
Esculsham				1							**1**
Gwauncaegurwen	1										**1**
Holyhead Joint Burial Committee					1						**1**
Llanbadrig			1								**1**
Llanfihangel Cwmdu with Bwlch & Cathedine			1								**1**
Llanidloes		1									**1**
Llannon		3									**3**
Monmouth			1								**1**
Nantmel		1									**1**
Newport Town									1		**1**
Pen-y-Cae	1										**1**
Pencoed	1										**1**
Penyffordd			1								**1**
Portskewett			1								**1**
St Asaph			1								**1**
Talybont-on-Usk			1								**1**
Tywyn		1									**1**
TOTAL	**3**	**7**	**10**	**1**	**1**			**1**	**1**	**1**	**25**

COMPLAINTS CONCERNING NHS BODIES
Local Health Boards

Local Health Boards	Out of Jurisdiction	Premature	Investigation Not Merited	Discontinued	Quick Fix/Vol Settlement	S16 Report Upheld – in whole or in part	S16 Report Not upheld	Other Report Upheld - in whole or in part	Other Report Not upheld	Withdrawn	Total Cases Closed
Anglesey			1		1						**2**
Blaenau Gwent			1		1						**2**
Bridgend				3							**3**
Caerphilly				1							**1**
Cardiff		1	1	1	2	4		1	1		**11**
Carmarthenshire		1									**1**
Ceredigion						1					**1**
Conwy		2	2	1	1	1				1	**8**
Gwynedd	1							1			**2**
Monmouthshire		1	1								**2**
Neath Port Talbot				1				1			**2**
Newport						1					**1**
Pembrokeshire	1	1				1					**3**
Powys		2	4	2				1			**9**
Rhondda Cynon Taf		1									**1**
Swansea								1	1		**2**
Torfaen						1					**1**
Vale of Glamorgan				1				1			**2**
TOTAL	**2**	**9**	**10**	**10**	**5**	**9**		**6**	**2**	**1**	**54**

NHS Trusts

NHS Trust	Out of Jurisdiction	Premature	Investigation Not Merited	Discontinued	Quick Fix/Vol Settlement	S16 Report Upheld – in whole or in part	S16 Report Not upheld	Other Report Upheld - in whole or in part	Other Report Not upheld	Withdrawn	Total Cases Closed
Abertawe Bro Morgannwg University NHS Trust		2	2	3				2		1	**10**
Bro Morgannwg		1		1				2	1		**5**
Cardiff & Vale	1	5	7	4		1		4	1	1	**24**
Carmarthenshire		1		2				2	1	1	**7**
Ceredigion & Mid Wales						1		1			**2**
Conwy & Denbighshire		2		4					1		**7**
Cwm Taf	1	1									**2**
Gwent Healthcare		9	10	6	2	1		4	1	2	**35**
Hywel Dda		2	3	1						1	**7**
North East Wales		1	1	3				1	2		**8**
North Glamorgan				1				2	1		**4**
North Wales	1		5	1							**7**
North West Wales	1			5				2			**8**
Pembrokeshire & Derwen	1		1	1		1		2			**6**
Pontypridd & Rhondda				2				2			**4**
Swansea		1	1	1				5	3		**11**
Velindre	1			1							**2**
Welsh Ambulance Services	1	1	1	1							**4**
TOTAL	**7**	**26**	**31**	**37**	**2**	**4**		**29**	**11**	**6**	**153**

COMPLAINTS CONCERNING NHS BODIES
Other Health Bodies

Other Health Bodies	Out of Jurisdiction	Premature	Investigation Not Merited	Discontinued	Quick Fix/Vol Settlement	S16 Report Upheld – in whole or in part	S16 Report Not upheld	Other Report Upheld - in whole or in part	Other Report Not upheld	Withdrawn	Total Cases Closed
Dentists		2		2				1	1		**6**
GPs	1	9	5	11				6	2	2	**36**
Ynys Mon Community Health Council			1								**1**
TOTAL	**1**	**11**	**6**	**13**				**7**	**3**	**2**	**43**

Independent Health Providers	Out of Jurisdiction	Premature	Investigation Not merited	Discontinued	Quick Fix/Vol Settlement	S16 Report Upheld – in whole or in part	S16 Report Not upheld	Other report Upheld - in whole or in part	Other Report Not upheld	Withdrawn	Total Cases Closed
Glais House Nursing Home Ltd									1		**1**
Primecare								1			**1**
TOTAL								**1**	**1**		**2**

COMPLAINTS CONCERNING REGISTERED SOCIAL LANDLORDS (HOUSING ASSOCIATIONS)

Registered Social Landlords	Out of Jurisdiction	Premature	Investigation Not Merited	Discontinued	Quick Fix/Vol Settlement	S16 Report Upheld – in whole or in part	S16 Report Not upheld	Other Report Upheld - in whole or in part	Other Report Not upheld	Withdrawn	Total Cases Closed
Bron Afon Community		2	1	1							**4**
Cadwyn		1									**1**
Cardiff Community			2	1					1		**4**
Charter Housing Association (1973)			2	2							**4**
Clwyd Alyn		1			2				1	1	**5**
Cymdeithas Tai Clwyd								1			**1**
Cymdeithas Tai Hafan									1		**1**
Family Housing Association (Wales) Ltd		2	2								**4**
Grŵp Gwalia Cyf Ltd		2		1							**3**
Gwalia (Rest Bay Co-Ownership Equity Sharing)				1							**1**
Hafod Care				2							**2**
Hafod	1		1								**2**
Melin Homes	1		3		1						**5**
Mid Wales		1									**1**
Newport Housing					1						**1**
North Wales			1	1							**2**
Pembrokeshire				1							**1**
Pennaf				1							**1**
RCT Homes		2	2	1	2						**7**
Swansea		1			1						**2**
United Welsh		1	1	1				1			**4**
Valleys to Coast		4	2	1							**7**
Wales and West		6	4	5	3			1			**19**
TOTAL	**2**	**23**	**21**	**19**	**10**			**3**	**3**	**1**	**82**

COMPLAINTS CONCERNING THE WELSH ASSEMBLY GOVERNMENT & ASSEMBLY GOVT . SPONSORED BODIES

Welsh Assembly Government and Sponsored Bodies	Out of Jurisdiction	Premature	Investigation Not Merited	Discontinued	Quick Fix/Vol Settlement	S16 Report – Upheld – in whole or in part	S16 Report Not upheld	Other Report – upheld in whole or in part	Other Report Not upheld	Withdrawn	Total Cases Closed
Welsh Assembly Government											
Welsh Assembly Government	4	3	16	3				3	1		**30**
CAFCASS Cymru	2	3	3								**8**
Health Commission Wales	1		3	1	1						**6**
Independent Complaints Secretariat			1								**1**
Independent Review Secretariat			1						1		**2**
Planning Inspectorate	1	5	3					1			**10**
Welsh Assembly Government (OCMO)			1								**1**
Welsh Assembly Government (Transport Wales)			1								**1**
Assembly Government Sponsored Body											
Arts Council for Wales			1								**1**
Countryside Council for Wales			1								**1**
Environment Agency		2	4	1	1			2			**10**
Office of Her Majesty's Chief Inspectors of Education & Training in Wales (ESTYN)				1							**1**
The Forestry Commissioners (for matters relating to Wales)			1								**1**
TOTAL	**8**	**13**	**36**	**6**	**2**			**6**	**2**		**73**

OTHER BODIES

Other	Out of Jurisdiction	Premature	Investigation Not Merited	Discontinued	Quick Fix/Vol Settlement	S16 Report Upheld – in whole or in part	S16 Report Not upheld	Other Report Upheld - in whole or in part	Other Report Not upheld	Withdrawn	Total Cases Closed
East Wales Valuation Tribunal		1									**1**
West Wales Valuation Tribunal			1								**1**
Complaints received in respect of bodies not in jurisdiction where this had not been previously determined	6										**6**
TOTAL	**6**	**1**	**1**								**8**

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Further copies of this document may be obtained from the Public Services Ombudsman for Wales by making a request via any of the above contact methods.