Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

ANNUAL REPORT

2015/16

10 YEARS
OF PUTTING THINGS RIGHT


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The Annual Report 2015/16

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 2015/16

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1. Introduction by the Ombudsman

It is with great pleasure that I present this report for the year 2015/16, which was my first full year in office, and the tenth Annual Report of the Public Services Ombudsman for Wales since the office was established on 1 April 2006.

I see my Annual Report as having two key purposes:

1. to report on the performance and work of my office over the past year
2. to draw the attention of the National Assembly and the people of Wales to the messages that emerge from the outcomes of the complaints made to me regarding any areas of concern in relation to the nation's public service delivery.

However, with the office celebrating its 10 years anniversary, it is also appropriate in this Annual Report to reflect on the journey since 1 April 2006, from being the 'new kid on the block' to becoming a mature and well respected ombudsman scheme. This report therefore also looks back on some of the key developments over the past decade.

Whilst the ombudsman scheme in Wales is well respected at home and abroad, I feel strongly that we must ensure that it is fit for purpose not only for today but also tomorrow. It is important that we understand the office's journey of the past; but we need to do so in the context of ensuring that Wales also has the modern ombudsman scheme that it deserves to the future. That is why I have been particularly pleased that the Finance Committee of the National Assembly for Wales agreed to undertake an inquiry into the powers of the Public Services Ombudsman for Wales, and that a draft Public Services Ombudsman (Wales) Bill has resulted from this. I discuss this in greater detail later in this report, but would like to take the opportunity here to record my sincere thanks to Mrs Jocelyn Davies, AM, Chair of the Finance Committee and to all the Committee members for their diligent work in this matter. I sincerely hope that the new Fifth Assembly will decide to take the Draft Bill forward, introducing it as one of its first pieces of legislation after the Assembly May 2016 election.

Whilst I am passionate about the need for the PSOW's powers to be strengthened and extended through new legislation, I have also since taking up post been considering what initiatives I can introduce to address current issues facing the office. As I reported last year, the year on year volume increase of casework was a matter of concern and I was seeking ways that would allow us to 'turn the curve'. During the past year, I introduced some staffing changes at my office, key amongst these was enhanced roles for a number of investigation staff to include 'improvement officer' duties. This places a greater emphasis on best practice, corporate cultural development, and ending cycles of poor service delivery. Whilst the new arrangements are still in their early days, I have been very pleased with the progress that has been made. To complement these changes I wanted to enhance our external communication activity and, therefore, increased the office resource accordingly. I was particularly pleased that we were able to issue a thematic report this year. This brought to public attention an area of concern emanating from the investigations of my office in relation to poor quality hospital care 'out of hours'.

At the same time that the work above was in progress, my staff and I also worked together to produce a new three year strategic plan to take us forward to 2018/19. This resulted in a new Vision, Mission, Values and Strategic Aims. I am extremely pleased with the outcome of this work and grateful to my team for the enthusiastic way that they engaged with this process. I am grateful too to the PSOW's Advisory Panel Members who also contributed to the development of the plan.

We also continued with a number of outreach activities during the year, this included giving particular attention to improving our provision for those people who are deaf or have hearing difficulties. More information about our outreach work during the year can be found in my 'annual equality report' found at Section 8 of this report.

However, by far the greatest activity of the office during the year of course was the core business of considering the complaints made to me. Whilst overall, the office caseload (which includes both enquiries and complaints) was up by 4%, interestingly and for only the second time since the creation of the office, there was a fall in the complaints received about public service providers (down 4% compared to 2014/15). Notably, the only sector that saw an increase in complaints to my office was the NHS in Wales, which was up by 4%; complaints about all other sectors fell to different degrees.

I have previously spoken about wanting to ensure that the resource of my office is devoted to issues of real concern rather than trivial complaints about the Code of Conduct. It is of particular disappointment to me therefore that complaints alleging that councillors had breached their authority's Code rose by 19%. This is solely attributable to community and

town councils, where complaints about members of these councils rose by 49%. I have been particularly pleased that the public interest test I introduced last year has helped my office in dealing with these complaints in an effective manner. I discuss this further at section 4 of this report.

Finally, I would like to thank my staff and the Advisory Panel for their support during the past year. For many members of staff it has involved direct changes to their roles and for others there have been associated effects. I am truly grateful to them for their positive attitude to the new arrangements and their continued professionalism in our common aim of ensuring administrative justice for public service users and improving public service delivery in Wales.

Nick Bennett
Ombudsman

2. My Role as the Public Services Ombudsman for Wales

As Ombudsman, I have two specific roles. The first is to consider complaints about public services providers in Wales; the second role is to consider complaints that members of local authorities have broken the Code of Conduct. I am independent of all government bodies and the service that I provide is free of charge.

Complaints about Public Service Providers

Under the PSOW Act 2005, I consider complaints about bodies which, generally, are those that provide public services where responsibility for their provision has been devolved to Wales. The types of bodies I can look into include:

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

I am also able to consider complaints about privately arranged or funded social care and palliative care services.

When considering complaints, 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 service provider. Attention will also be given to whether the service provider has acted in accordance with the law and its own policies. If a complaint is upheld I will recommend appropriate redress. The main approach taken when recommending redress is, where possible, to put the complainant (or the person who has suffered the injustice) back to the position they would have been in if the problem had not occurred. Furthermore, if from the investigation I see evidence of a systemic weakness, then recommendations will be made with the aim of reducing the likelihood of others being similarly affected in future.

A New PSOW Act?

I have outlined above the key features of my role as Ombudsman. However, during the course of the year the Finance Committee of the National Assembly for Wales conducted an inquiry into the Ombudsman's powers. Following its report on the inquiry, a Draft PSOW Bill was issued.

I was extremely pleased to see that included in the Draft PSOW Bill were the following proposals, enhancing the existing powers of the PSOW:

- the ability to undertake own initiative investigations;
- the ability to accept oral complaints;
- the ability to consider complaints about private hospitals in circumstances where a patient's pathway has involved treatment and/or care by both public and private health care providers;
- a complaints standards authority role.

Having then conducted a public consultation on the Draft Bill, in the introduction to the resultant report, the Finance Committee Chair, Mrs Jocelyn Davies, AM, noted that rather than amending the 2005 Act, it was felt that the Ombudsman's role should be governed by Welsh legislation. The aim therefore was to create one piece of bilingual legislation which would repeal the PSOW Act 2005. The report contained a number of recommendations, the first of which was:

> Recommendation 1 - The Committee recommends that a future Committee of the National Assembly for Wales should introduce the Draft Public Services Ombudsman (Wales) Bill, as soon as possible, in the Fifth Assembly.
> (Source: National Assembly for Wales Finance Committee Consideration of the consultation on the Draft Public Services Ombudsman (Wales) Bill (March 2016))

I am delighted with the outcome of the Assembly Finance Committee's work. I have commented publicly in a number of places that I think it is vital that we ensure that the PSOW's legislative basis is sound and that we can claim to be genuinely fit for the future and that legislation:

- addresses future challenges affecting service users in an ageing society where there are greater levels of physical and emotional vulnerability;
- makes a real contribution to public service improvement and reform whilst offering excellent value for money;
- ensures that citizens from more deprived backgrounds will find it easier to make a complaint;
- strengthens the citizen's voice and ensures that wherever possible processes will follow the citizen rather than the sector or the silo.

I very much hope that the Fifth Assembly takes forward the Committee's recommendation, together with the others in its report, without delay after the May 2016 election and that new Welsh legislation will soon result.

Both Finance Committee reports referred to above are available on the Assembly's website: assembly.wales

Code of Conduct Complaints

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, I consider complaints that members of local authorities have breached their authority's Code of Conduct. I can consider complaints about the behaviour of members of:

- county and county borough councils
- community councils
- fire authorities
- national park authorities and
- police and crime panels.

All these authorities have a Code of Conduct which sets out in detail how members must follow recognised principles of behaviour in public life.

If a county councillor wishes to make a complaint about another county councillor within their own authority, then I expect them to first of all make their complaint to that authority's Monitoring Officer, as it may be possible to resolve the matter locally without my involvement.

Amendments to Legislation in Relation to the Model Code of Conduct

I very much welcomed the Welsh Government's amendments to legislation (in force from 1 April 2016). Below I draw attention to some of the key changes which impact on my role in relation to Code of Conduct complaints and are relevant to my office:

- **The Local Authorities (Model Code of Conduct) (Wales) (Amendment) Order 2016** - There is provision for a number of amendments in relation to the legislation on the Model Code of Conduct, all of which I have welcomed. Perhaps the key amongst these from my perspective is that the previous requirement placing an obligation on a local authority member to report a potential breach of the Code to me, as Public Services Ombudsman for Wales, has been omitted from the Code, but there continues to be the obligation to report such matters to the monitoring officer. However, if a matter remains unresolved following consideration by the monitoring officer, or the complaint raised is a serious one, then the complaint can then be referred on to me for consideration. This now supports the informal arrangement for resolving low level member against member complaints that this office has recently agreed with county or county borough councils. This amendment does not prevent a member from reporting a potentially serious breach of the Code to me.

- **The Local Government (Standards Committees, Investigations, Dispensations and Referral (Wales) (Amendment) Regulations 2016**

  These Regulations introduce a number of amendments in relation to:

  - The Standards Committee (Wales) Regulations 2001
  - The Local Government Investigations (Functions of Monitoring Officers and Standards Committee (Wales) Regulations 2001
  - Local Authorities (Grant of Dispensations) (Wales) Regulations 2001.

  In particular, I am pleased that:

  - provision has been made to enable a standards committee or a monitoring officer, with the prior written agreement of the Chairperson of the standards committee, to refer the report of a misconduct investigation to another authority's standards committee for determination with a view to overcoming any potential conflict of interest a standards committee may have in dealing with the complaint under consideration
  - two or more relevant authorities are now able to establish a joint standards committee
  - a member seeking to appeal the determination of a standards committee will in future first need to obtain the permission of the President, or a nominated panel member, of the Adjudication Panel.

These are all developments which this office has previously advocated and supported during past discussions with the Welsh Government and, indeed, with monitoring officers. I very much hope that these amendments will lead to both a more effective ethical standards system and a reduction in Code of Conduct complaints to my office and the associated staff resource.

3. Ten Years of the Ombudsman's Office – A retrospective of Annual Reports

Adam Peat is the first Public Services Ombudsman for Wales

2006/07

The journey begins - PSOW Act came into effect on 1 April 2006, creating a one stop shop for complaints about public service providers in Wales. It replaced the previous offices of the Commissioner for Local Administration in Wales, the Health Service Commissioner for Wales, the Welsh Administration Ombudsman, and the Social Housing Ombudsman.

2007/08

For first time health public interest investigation reports published (under previous Health Commissioner legislation making health investigation reports public was prohibited).

Focus on issuing guidance to public bodies on good administrative practice: Principles of Good Administration; and Principles for Remedy.

Peter Tyndall is now the Public Services Ombudsman for Wales

2008/09

New Strategic Plan introduced with emphasis on: being an accessible service, particularly for those in vulnerable circumstances; and streamlining PSOW complaints procedure to deal with the challenges faced due to increasing caseload.

2009/10

Complaints Advice Team created with greater emphasis on customer care, 'managing expectations' and proactive approach to Early Resolution (Quick Fix).

Guidance issued to councillors on the code of conduct for local authority members.

2010/11

Health complaints now account for quarter of all complaints to the office.

PSOW engages with Welsh Government and Assembly to propose addressing anomaly of lack of administrative justice available to people who self fund care and those who receive services from hospices.

2011/12

Work of group chaired by Ombudsman results in Welsh Government issuing Model Policy & Guidance for complaints handling for adoption by all public services providers in Wales.

Complaints Wales signposting service launched, to help people make complaints to public bodies about poor service.

NHS Redress Measure introduced and independent review stage removed; Ombudsman becomes sole independent reviewer of health complaints.

Peter Tyndall is the Public Services Ombudsman for Wales

2012/13

Ombudsman proposes reform of the PSOW Wales Act.

Ombudsman engages with Welsh Government and Assembly concerning lack of redress for people in receipt of public services delivered by private sector organisations, with particular reference to private health care.

Ombudsman reviews own governance arrangements and creates Advisory Panel.

Margaret Griffiths becomes Acting Ombudsman from December 2013

2013/14

A time of transition begins when Acting Ombudsman takes up role.

Trend of year on year increases in complaints continue, with health complaints having increased 146% over a period of five years. Health now accounts for 36% of all complaints to the office.

Social services complaints also begin to cause concern, with a 19% increase on previous year (although from a lower base in terms of number of complaints compared to other areas of complaint).

Nick Bennett is the Public Services Ombudsman for Wales from August 2014

2014/15

Ombudsman can now consider complaints about independent care providers where care is self funded, as well as hospices and domiciliary care.

Social Services Complaints Procedure (Wales) Regulations 2014 removes independent review stage; Ombudsman becomes sole independent reviewer of complaints about social services.

Assembly Finance Committee agrees to undertake a review into powers of the Ombudsman.

Ombudsman instigates innovation project to seek efficiency gains in face of ever increasing complaints caseload. Other work undertaken to 'turn the curve', includes increased emphasis on data gathering and review of staff resources.

Nick Bennett is Public Services Ombudsman for Wales

2015/16

Assembly publishes Draft Public Services Ombudsman Wales Bill.

Staff changes take place, to include introducing 'improvement officer' role and greater emphasis on external and internal communication.

And forward to the next ten years ...

... the PSOW's powers have by now been strengthened and the Ombudsman operates to the Public Services Ombudsman (Wales) Act 2016 ????

2006 10 2016 · ANNIVERSARY ·

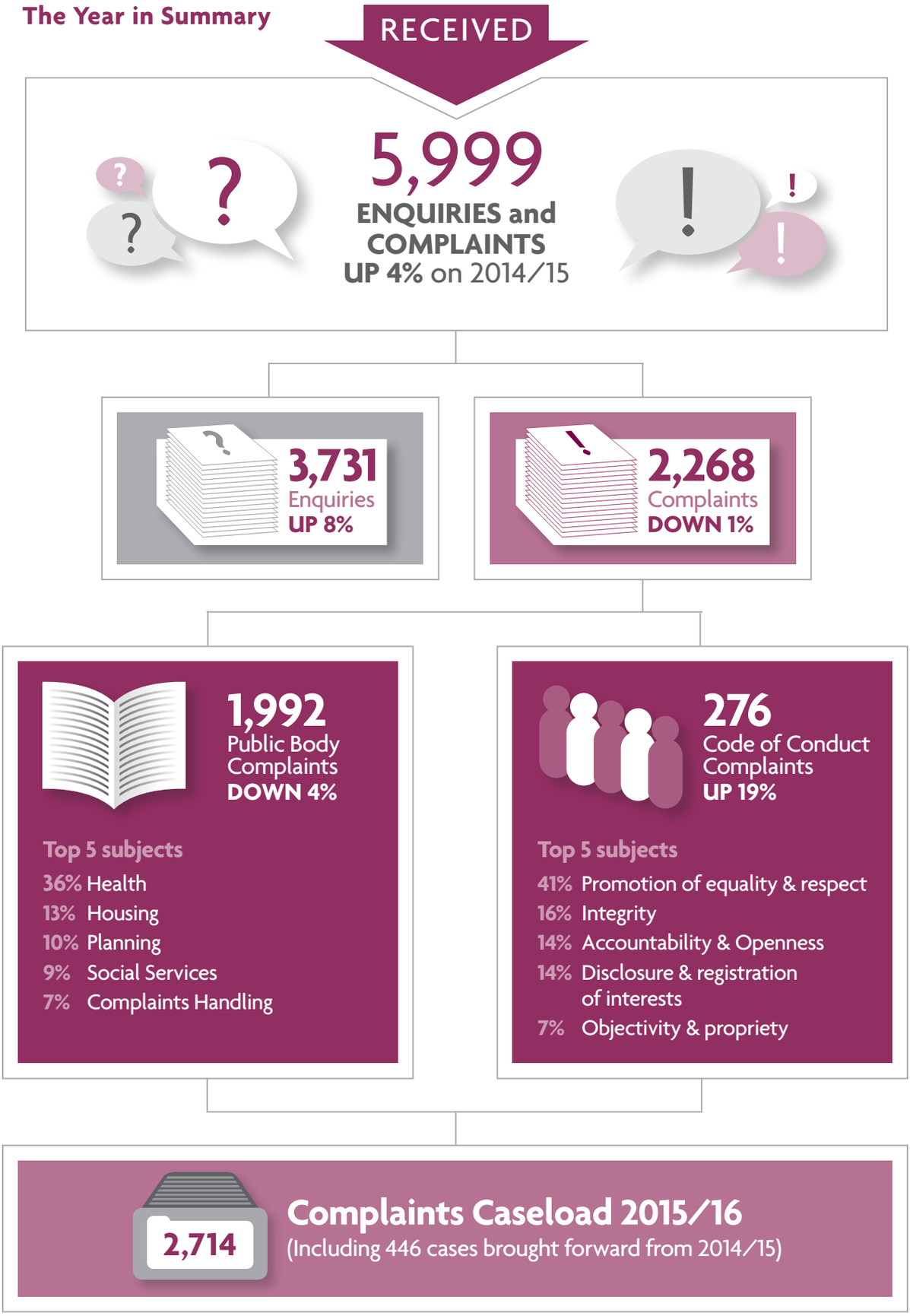
Celebrating 10 Years

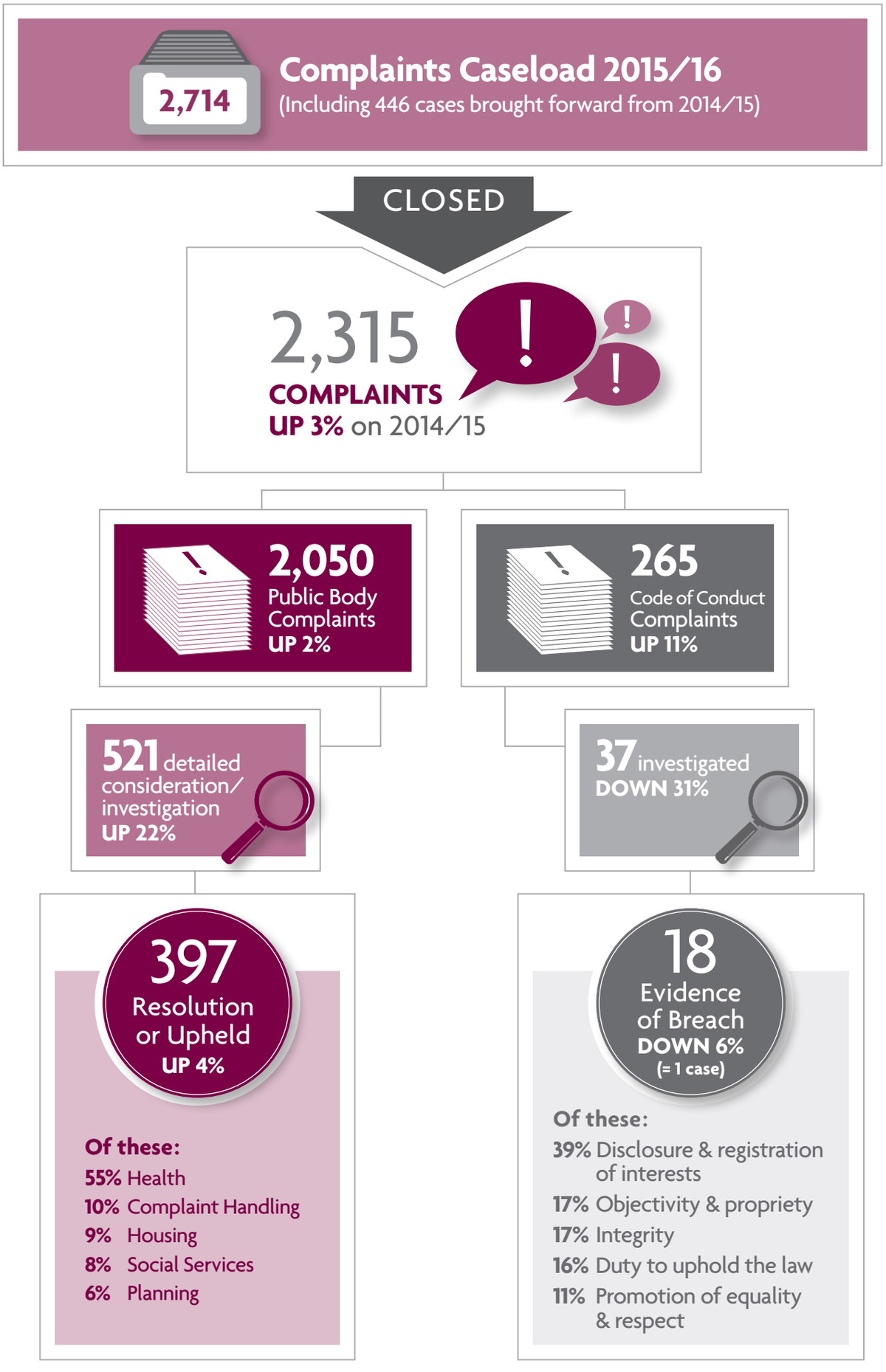
In recognising ten years of the Ombudsman's office, I was extremely grateful to Dame Rosemary Butler, the Presiding Officer, for agreeing to host an anniversary event at the Senedd Building. I was delighted that a number of Assembly Members, many public sector ombudsmen colleagues, other stakeholders and staff were able to join me to mark the occasion. It was an opportune time to reflect on the past achievements of the office as well as to look forward to the future.

Dame Rosemary Butler, Presiding Officer, welcomes Nick Bennett, Public Services Ombudsman for Wales and colleague public sector ombudsman at the Senedd

4. The Complaints Service

The Year in Summary

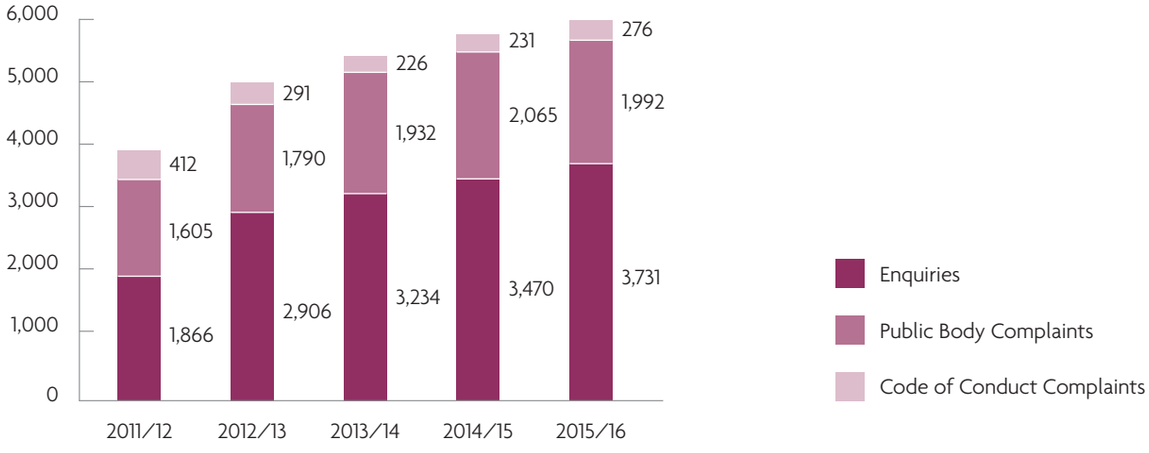



2,714
Complaints Caseload 2015/16
(Including 446 cases brought forward from 2014/15)
CLOSED
2,315
COMPLAINTS
UP 3% on 2014/15
2,050
Public Body Complaints
UP 2%
265
Code of Conduct Complaints
UP 11%
521 detailed consideration/ investigation
UP 22%
37 investigated
DOWN 31%
397
Resolution or Upheld
UP 4%
Of these:
55% Health
10% Complaint Handling
9% Housing
8% Social Services
6% Planning
18
Evidence of Breach
DOWN 6%
(= 1 case)
Of these:
39% Disclosure & registration of interests
17% Objectivity & propriety
17% Integrity
16% Duty to uphold the law
11% Promotion of equality & respect

Overall Casework

The number of enquiries and complaints (public body complaints, and complaints about the conduct of members of local authorities) totalled 5,999 during 2015/16 which is a 4% increase on the position for 2014/15. As can be seen from the chart below, comparing the position with that of five years ago, there has been a 54% increase. However, there are signs that the increases that the office has seen since the time it came into existence are beginning to plateau. I discuss the various aspects of this in greater detail below.

Total Enquiries and Complaints recieved by year



Enquiries

The office dealt with 3,731 enquiries during 2015/16, compared with 3,470 the previous year (an 8% increase). Compared with five years ago, this is a 100% increase. It is worth noting that February 2016 saw the highest ever number of enquiries made to this office.

An enquiry is a contact made by a potential complainant asking about the service provided, which does not, in the end, result in a formal complaint being made to me. At this point in our service we will advise people how to make a complaint to me or, where the matter is outside my jurisdiction, direct the enquirer to the appropriate organisation able to help them. Where appropriate, the Complaints Advice Team will also seek to resolve a problem at enquiry stage without taking the matter forward to the stage of a formal complaint.

We set ourselves the target of answering our main line reception calls within 30 seconds in 95% of cases. Yet again the Team performed impressively in this regard, answering 99% of calls within this timescale.

I am delighted that despite the continued increase in enquiries to this office we have maintained a prompt service at the frontline.

Public Body Complaints

For only the second time in the ten year history of the PSOW's office (the first being in 2008/09), there was a decrease in the complaints about public service providers compared with the previous year. We received 1,992 such complaints in 2015/16 compared with 2,065 in 2014/15, being a 4% decrease. There is no real identifiable reason for this and the number of complaints received month by month during the year was erratic, varying from being low one month, to high the next. I consider the complaints received by sector in further detail below.

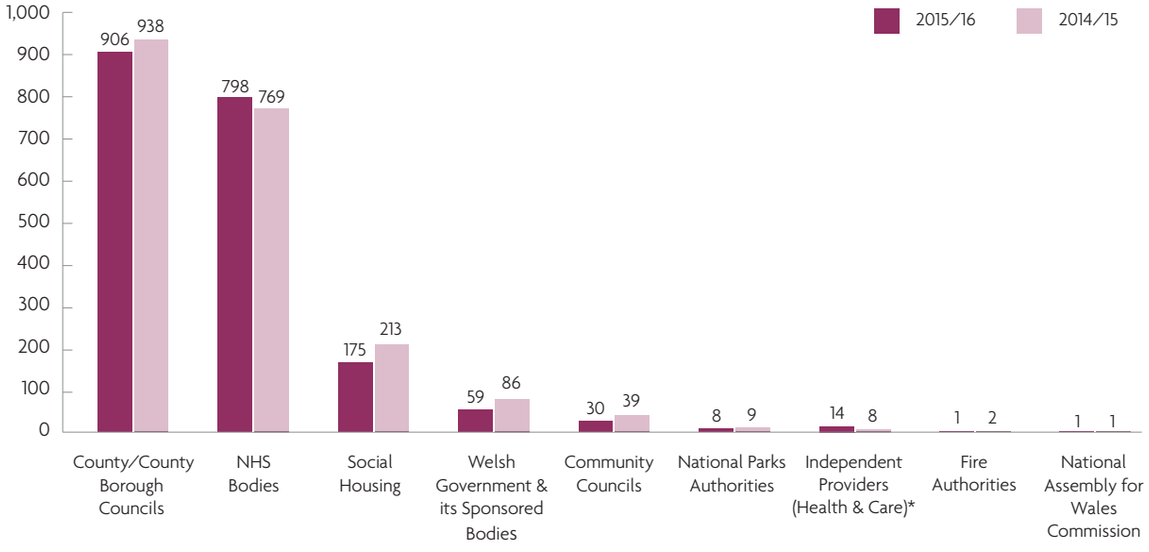
Sectoral breakdown of complaints

County councils provide the widest range of services amongst those in my jurisdiction. As usual, and as expected, it is this sector that was responsible for the most number of complaints that I received. Nevertheless, I was pleased to see a 3% decrease in the complaints about county councils over the past year, compared with 2014/15.

Indeed, there was a decrease in complaints across all sectors, with one exception. That exception was the NHS sector in Wales. This includes complaints about local health boards, NHS trusts, GPs and dentists. There was a 4% increase in complaints about health bodies compared with 2014/15 (798 compared with 769). Of the 798 health body complaints, local health boards and NHS trusts accounted for 661 of them. Within this there is a variation: there were fewer complaints about some health boards/trusts compared to last year, but a notable increase in complaints in respect of others in particular Abertawe Bro Morgannwg UHB and Betsi Cadwaladr UHB.

The chart below shows the distribution of the complaints received by sector.

Complaints by public body sector



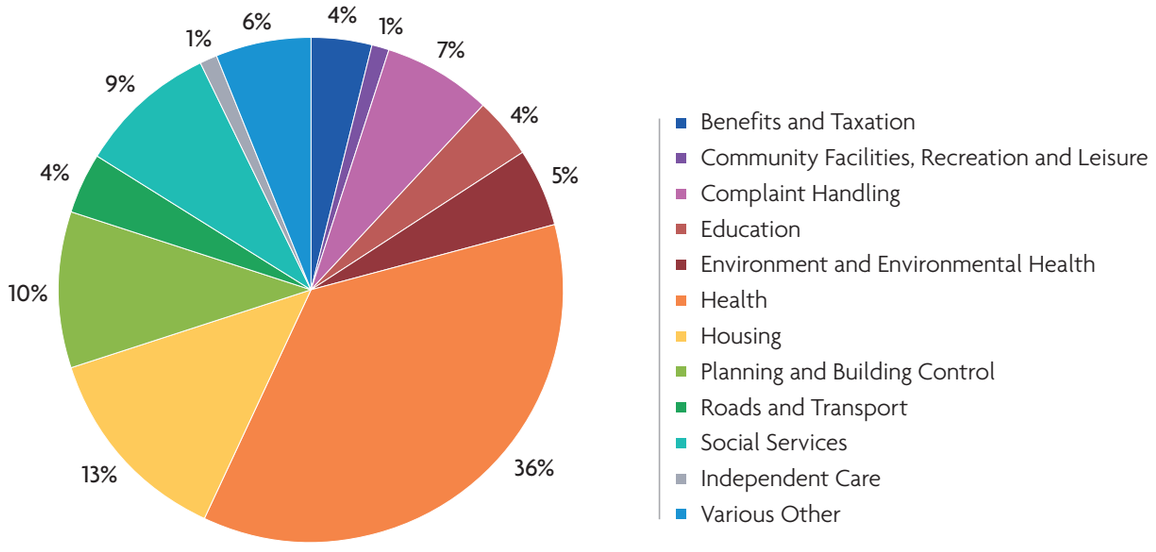
* The PSOW was able to accept complaints about independent self funded care from 1 November 2014

Complaints about public bodies by subject

Complaints to me can have many aspects to them, however, the chart below illustrates the main subject of the complaints I have received over the past year. Once again, health was the major part of the office caseload, but this year accounting for 36% of this compared with 34% in 2014/15. We have already seen that there has been an increase in complaints about NHS bodies, however, the percentage increase also arises from the fact that there have been fewer complaints about other public services. As has been the case in recent years, housing (13%) and planning (10%) are the service areas which are account for the greatest number of complaints received after health complaints.

Last year I commented on the increase being seen in relation to complaints about social services. This year there has been no significant increase in this type of complaint compared with 2014/15.

Complaints by subject 2015/16



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

Outcomes of complaints considered

We closed 2,050 complaints about public service providers during the past year compared with 2,015 in 2014/15, (an increase of 2%). A summary of the outcomes is set out in the table below and detailed breakdowns of the outcomes by public service provider can be found at Annex B.

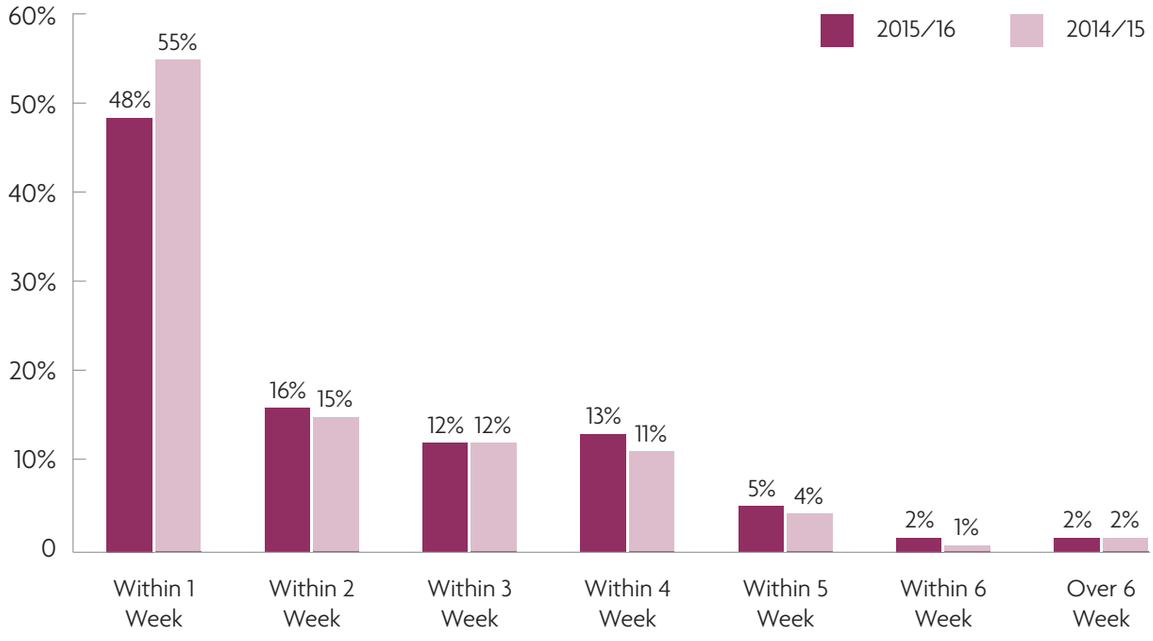
I am pleased that staff have managed to achieve this level of closure during the year, together with the fact that the number of cases on hand at the end of 2015/16 stood at 412, compared with 446 at the end of 2014/15 (which is a reduction of 8%). This is well within what I consider to be a reasonable caseload for the office to have open at any one time and this not a backlog. In addition to this, there was a 20% increase in the number of cases where we either achieved an informal resolution or took a complaint into investigation. However, there was a reduction in the number of public interest reports issued.

Complaint about a Public Body	**2015/16**	**2014/15**
Closed after initial consideration	1,488	1,564
Complaint withdrawn	41	23
Complaint settled voluntarily (includes 182 "quick fix" of cases)	227	164
Investigation discontinued	19	8
Investigation: complaint not upheld	105	71
Investigation: complaint upheld in whole or in part	163	173
Investigation: complaint upheld in whole or in part – public interest report	7	12
Total Outcomes – Public Body Complaints	**2,050**	**2,015**

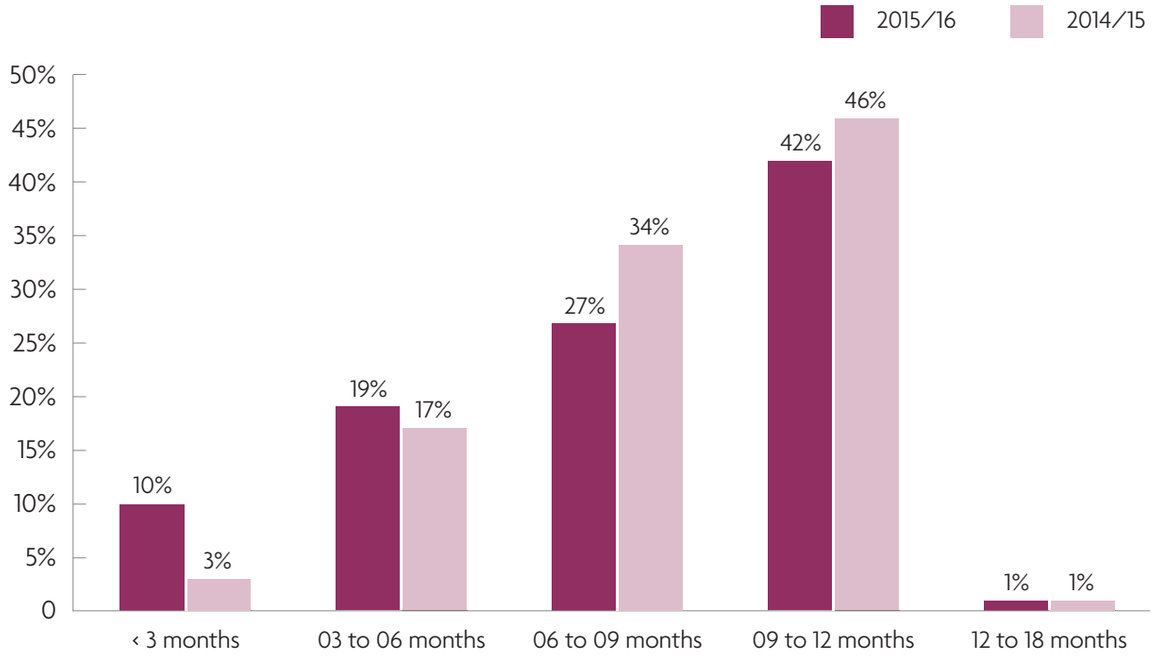
Decision times

Time taken to tell the complainant if I will take up their complaint

We set ourselves the target to tell complainants whether or not I will take up their complaint (from the date that sufficient information is received) within four weeks in 90% of cases. We just missed this target, doing so in 89% of cases (compared with 92% during 2014/15). Whilst disappointing, this is not a surprise to me in view of the continued increase in casework volume being dealt with by the Complaints Advice Team. We have been reviewing this target, and have been assessing whether a blanket four week target for all the various types of complaint consideration at this stage is now realistic and achievable in view of the level of casework. For example, at this stage, the Complaint Advice Team will endeavour to achieve, where appropriate, an early resolution to a complaint.



Similar to 2014/15, we again completed 99% of investigations within 12 months, against the 100% target we set ourselves. There were five investigations that went over 12 months. Largely these cases were complex with serious challenges which required further investigatory work. The chart below gives further details on investigation timescales.



Code of Conduct Complaints

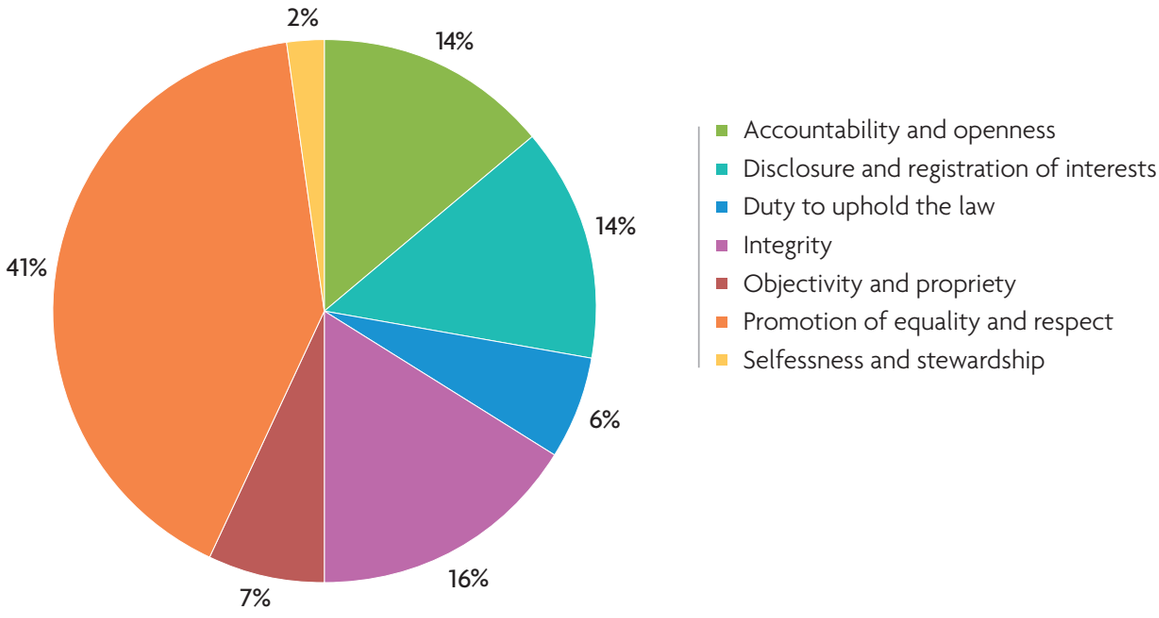
Complaints received

The number of Code of Conduct complaints rose by 19% compared with 2014/15 (274 in 2015/16 against 231). It is disappointing to see this rise, especially in relation to community councils where there has been a 49% increase.

	2015/16	2014/15
Community Council	158	106
County/County Borough Council	115	125
Fire Authority	0	0
National Park Authority	1	0
Police & Crime Panels	0	0
Total	**274**	**231**

Nature of Code of Conduct complaints

By far the majority of complaints received during 2015/16 related to matters of 'equality and respect', accounting for 41% of the complaints made to me (this was 35% in 2014/15). The next largest area of complaint related to 'integrity' at 16%, and then 'disclosure and registration of interests' and 'accountability and openness' both of which accounted for 14% of the Code of Conduct caseload.



Summary of Code of Conduct complaint outcomes

Consistent with previous years, the vast majority of these complaints (213 of them) were closed under the category 'Closed after initial consideration' (178 were closed in this way in 2014/5). This includes decisions such as:

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

Despite the higher level of complaints received, fewer were taken into full investigation (27 in 2015/16 compared with 34 the previous year). I largely attribute this to be the result of a key change over the past year whereby I introduced a 'public interest test'. This test was developed as a result of the high number of trivial complaints received at my office, and to make clear the criteria that I will apply when considering whether a complaint should be taken into investigation or not. It also ensures that I continue to investigate serious complaints to maintain public confidence in standards of public life.

Of those 27 cases that were fully investigated, six were referred to either a standards committee or the Adjudication Panel (nine were referred in 2014/15). In such circumstances it is for these bodies to consider the evidence found, together with any defence put forward by the member concerned. It is then for them to determine whether a breach has occurred and, if so, what penalty, if any, should be imposed. Whilst at the time of writing three cases await consideration, decisions have been arrived at on the other three cases, as follows:

Hearing by:	Decision & Sanction	Nature of breach of Code
Standards Committee	Breach of Code - Councillor suspended for one month	Duty to uphold the law
Standards Committee	Breach of Code - Councillor suspended for one month	Disclosure and registration of interests
Tribunal of Adjudication Panel for Wales	Breach of Code - Councillor suspended for three months and to receive training during this time.	Disclosure and registration of interests

A breakdown of the outcomes is below:

	2015/16	2014/15
Closed after initial consideration	213	178
Complaint withdrawn	15	7
Investigation discontinued	10	20
Investigation completed: No evidence of breach	11	17
Investigation completed: No action necessary	10	8
Investigation completed: Refer to Standards Committee	3	8
Investigation completed: Refer to Adjudication Panel	3	1
Total Outcomes – Code of Conduct complaints	**265**	**239**

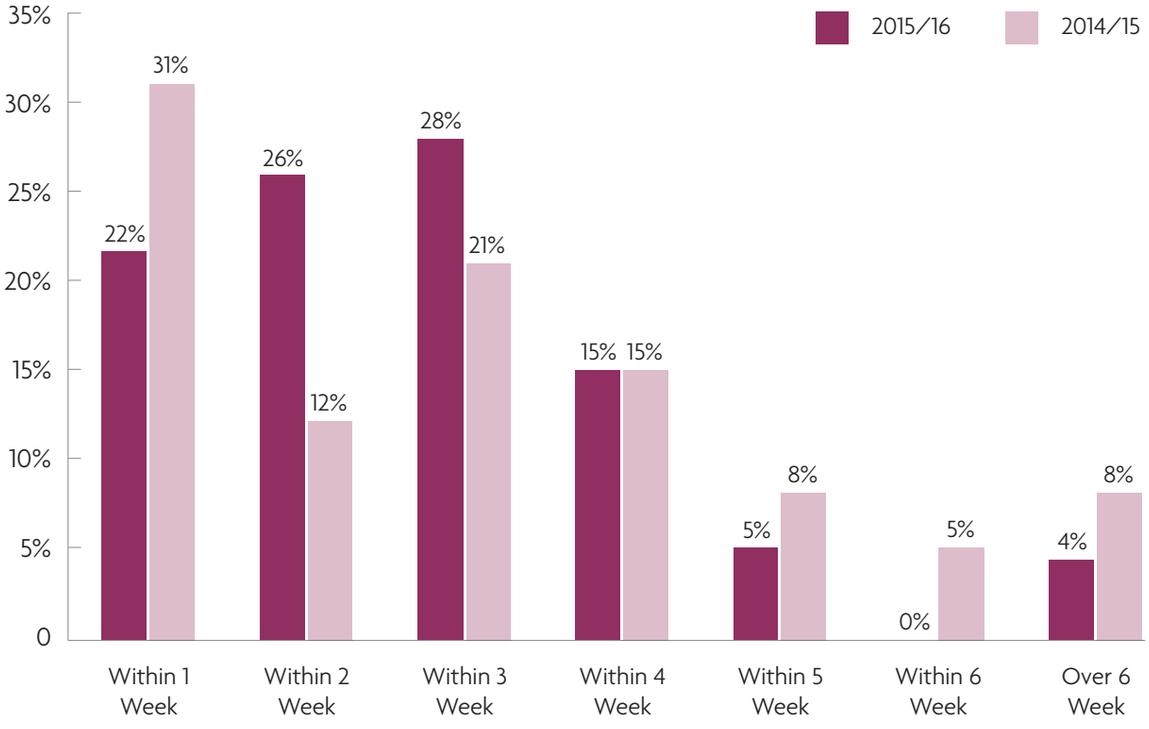
A detailed breakdown of the outcome of Code of Conduct complaints investigated, by authority, during 2015/16 is set out at Annex C.

Decision times

Time taken to tell the complainant if I will take up their complaint

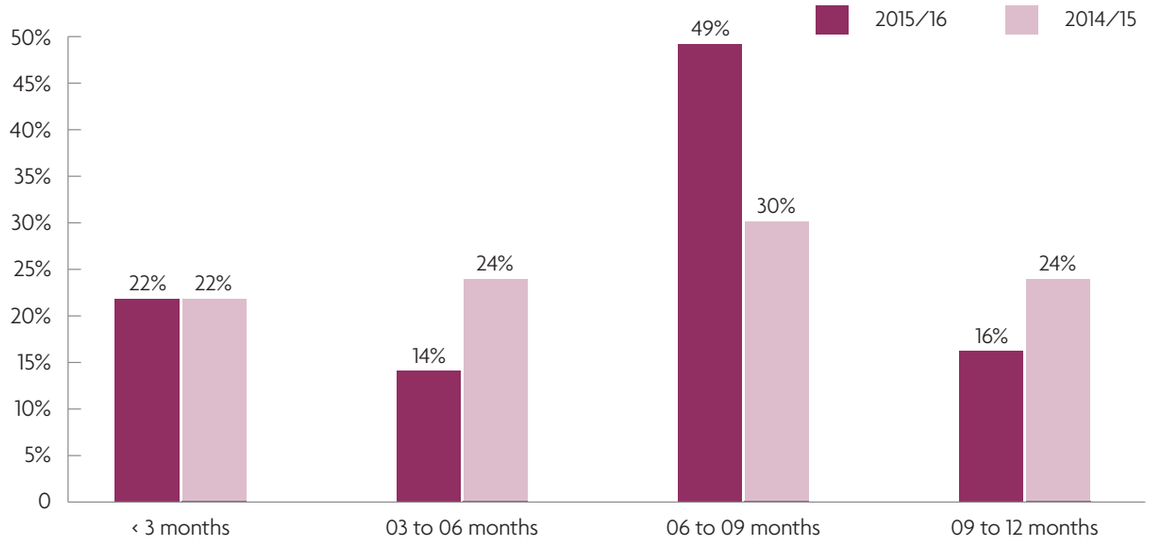
In respect of Code of Conduct complaints, 91% of complainants were informed within four weeks of whether I would take up their complaint (from the date that sufficient information is received). I'm particularly pleased that we surpassed our 90% target in this regard. Last year I reported that we achieved the four week target in 79% of cases and that I would work with my staff during this past year to ensure that we advise both the complainant and the accused member promptly as to whether I will take the matter into investigation or not. In addition to this improvement against the four week target, it is also worth noting that 96% had been informed within five weeks. My staff and I are always mindful of the fact that being the subject of a complaint can be a stressful and serious matter for the member being complained about.

Further details on these decision timescales are shown below.



Decision times for concluding Code of Conduct investigations

Comparing performance against 2014/15, in addition to the improvement in meeting the four week target, as discussed above, I am also pleased that there was an improvement on closing investigations within twelve months. Furthermore, as the chart below shows, during the past year 85% of Code of Conduct investigations were completed within 9 months, compared with 76% in 2014/15.



5. Improving Public Services

It is important to me that not only do we put things right for users of public services when poor service has been identified, but that as a consequence of our work improvements occur in those areas of service delivery where we have identified failings. Below I describe some of the initiatives introduced this year to build on already established practices in this regard.

Improvement Officers

In particular, during the course of the year I introduced into the roles of a number of investigation staff in my office, the additional role of 'improvement officer'. Whilst the main element of their role remains the investigation of complaints, their improvement role will include stakeholder engagement with certain bodies in jurisdiction as well as subject leads for areas which continue to affect quality public services.

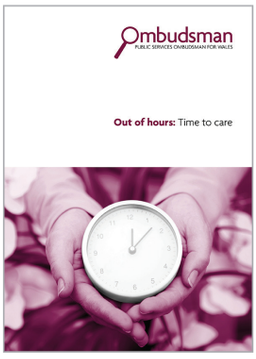
Those organisations assigned an Improvement Officer were: Abertawe Bro Morganwg UHB, Aneurin Bevan UHB, Betsi Cadwaladr UHB, Cardiff and Vale UHB, Hywel Dda UHB and Ceredigion County Council. In engaging with these bodies we hope to see ongoing improvements in complaints handling, learning and putting things right, along with the governance arrangements necessary for continuous improvement. We will regularly review our data, and the insights we gain from these arrangements, to identify any improvements. I will in due course consider whether it would be beneficial to extend this approach to other bodies.

Subject leads are now in place for:

- health (with a separate lead for clinical advice)
- housing
- local government planning services
- social services, and
- the code of conduct for local authority members.

Subject leads are specifically tasked with identifying trends from casework across the office, leading on thematic reports, and monitoring legislative and other developments affecting the subject area.

Thematic Reports



The first thematic report emerging from the new approach described above was published in March 2016. The report entitled 'Out of Hours: Time to Care' highlighted a number of cases investigated that showed inadequate standards of care given to patients in hospitals across Wales outside of 'normal' working hours.

As I can currently only look at complaints submitted to me by service users, my report called for an independent systemic review on out of hours care. In particular I identified the following areas for attention:

- inadequate consultant cover across seven days
- delays in medical review and lack of consultant review
- lack of senior supervision for junior medical staff
- failure to meet pre-existing standards of care and established guidelines.

Whilst I did not suggest that the failures in care identified by my office were typical of health service delivery in Wales's hospitals, they did not appear to be isolated incidents. An independent systemic review would confirm whether or not there were any emerging patterns or inconsistencies in quality of care in this area and, if so, allow for them to be addressed appropriately.

In addition to the above there were other activities during the year in relation to the goal of improving service delivery. In particular, I was pleased to be able to publish a joint publication with the Information Commissioner:

- **Principles of Good Administration and Good Records Management** - This was a revision of the 'Principles of Good Administration' originally issued by the Ombudsman in 2008. I was delighted to be able to work with the Information Commissioner in reviewing this document, which now includes two new Principles in relation to good records management. Following consultation with bodies within my jurisdiction, the new document was published in February 2016.

- **Enhanced Data Capture** – We have also during the year reviewed the level of data that we capture in relation to the complaints made to me, with particular focus on health complaints in the first instance. The aim is to enable us to identify trends at a more micro rather than macro level. As we only begun inputting data at this level during this year, it is too early to have been able to benefit from this yet. However, I hope that we will be able to derive useful information to act upon during 2016/17.

Furthermore, sight should not be lost of the already established vehicles used to highlight areas for service delivery improvements by bodies in jurisdiction. These included:

- **Public interest reports** – Seven such reports were issued during 2015/16 and summaries of these investigation reports together with findings and outcomes are set out at Annex A. The full reports are available on my website at www.ombudsman-wales.org.uk.

- **The Ombudsman's Casebook** – These continued to be published quarterly. Four main areas highlighted for service improvement in the publications issued during the year were:
  - services for vulnerable citizens
  - reducing the distress of dying - why improvements are needed to end of life care
  - GP services
  - special needs education.

- **The Code of Conduct Casebook** – At the request of its readership, we began issuing these quarterly during 2015/16 rather than on a six monthly basis, which was our previous practice. An annual commentary by me is to appear in the April editions of the Casebook.

- **Annual letters** – These are issued to county councils and health boards and used as the basis of discussions with the Chairs and Chief Executives of individual local health boards. Local authorities are also invited to seek a meeting to discuss their particular Annual Letter if they so wish. It is intended that the Annual Letters to be issued during 2016 in respect of the operational year 2015/16 will for the first time include an improvement officer's commentary in relation to those bodies assigned an improvement officer.

6. Governance and Accountability

The Ombudsman

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

I appeared before an Assembly committee on a number of occasions during the past year. This included the Communities, Equality and Local Government Committee to discuss the Annual Report for 2014/15; and the Finance Committee to discuss my budget estimate submission for 2016/17. I also appeared before the Finance Committee in relation to providing evidence to its inquiry into the PSOW's powers. I welcomed the opportunity on each occasion to discuss not only the work already undertaken by my office, but also what the work of the office could look like in the future.

Advisory Panel and Audit & Risk Assurance Committee

As reported last year, although a corporation sole, I have an Advisory Panel which provides both challenge and support to me as Ombudsman. There is also an Audit & Risk Assurance Committee, a sub-committee of the Panel. Having reviewed the level of membership during the past year, I decided to strengthen its membership by one additional member. An open/public recruitment exercise was conducted. I was very pleased to appoint Mr Jonathan Morgan from a strong field of candidates. Mr Morgan served as an Assembly Member for 12 years, and is a former Chair of the National Assembly Public Accounts Committee. He joined the Panel in March 2016 and will also be a member of the PSOW's Audit & Risk Assurance Committee.

The work of both the Panel and the Committee over the past year will be reported in greater detail as part of the Governance Statement within my Annual Accounts for 2015/16.

Management Team

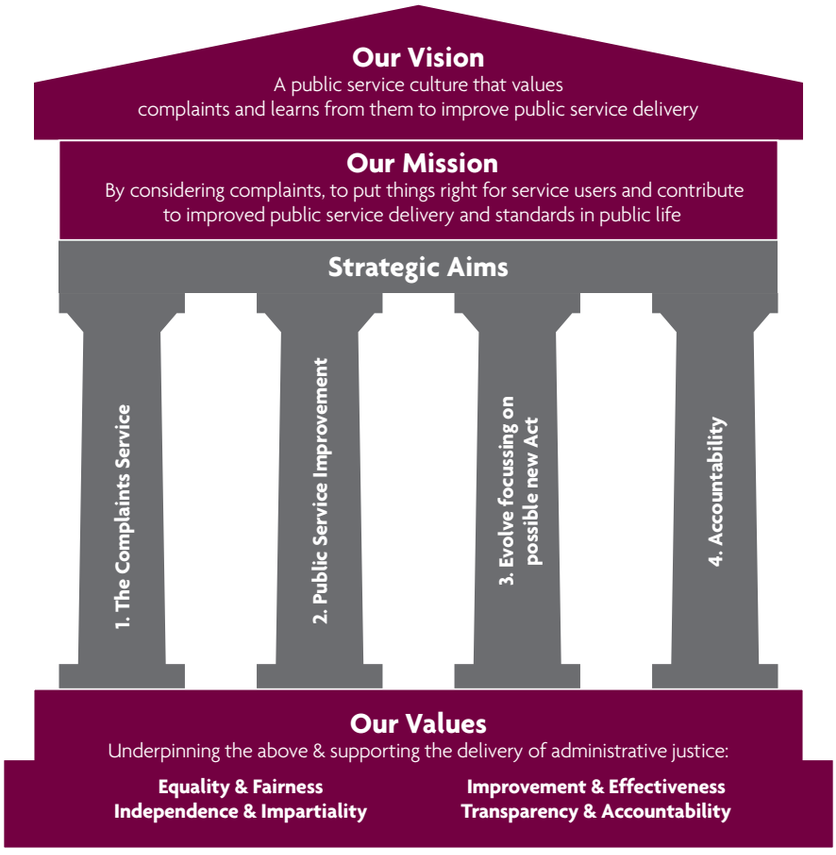
The Management Team has continued to support and advise me in relation to strategic direction as well as the operational, day to day, running the office. I am particularly grateful to them this year for ensuring a successful and seamless staffing and operational transition. The revised staffing structure can be found at page 30.

Three Year Strategic Plan

This was the final year of the existing strategy and, therefore, during the year, my staff and I developed a new three year strategic plan for the office to the operational year 2018/19. We held a number of workshops, which proved to be very productive. A separate workshop was also held for Advisory Panel Members and I was very grateful to them for their contribution. A new Vision, Mission, Values and Strategic Aims resulted from this work.

Whilst taking forward the service under the existing powers of the Ombudsman was a key focus for our discussions, I felt that it was important that we created space in our strategic planning to implement any new PSOW Act that might be created during the lifetime of the plan. However, I wish to reinforce the message in this report that in doing so I have not taken anything for granted in relation to the introduction of new legislation or what that legislation might contain.

Below is an illustrated summary of the strategic plan, the full text of the Strategic Aims can be found in the comprehensive document entitled 'Three Year Strategic Plan 2016/17 to 2018/19: Innovation, Influence, Improvement' on the website: www.ombudsman-wales.org.uk

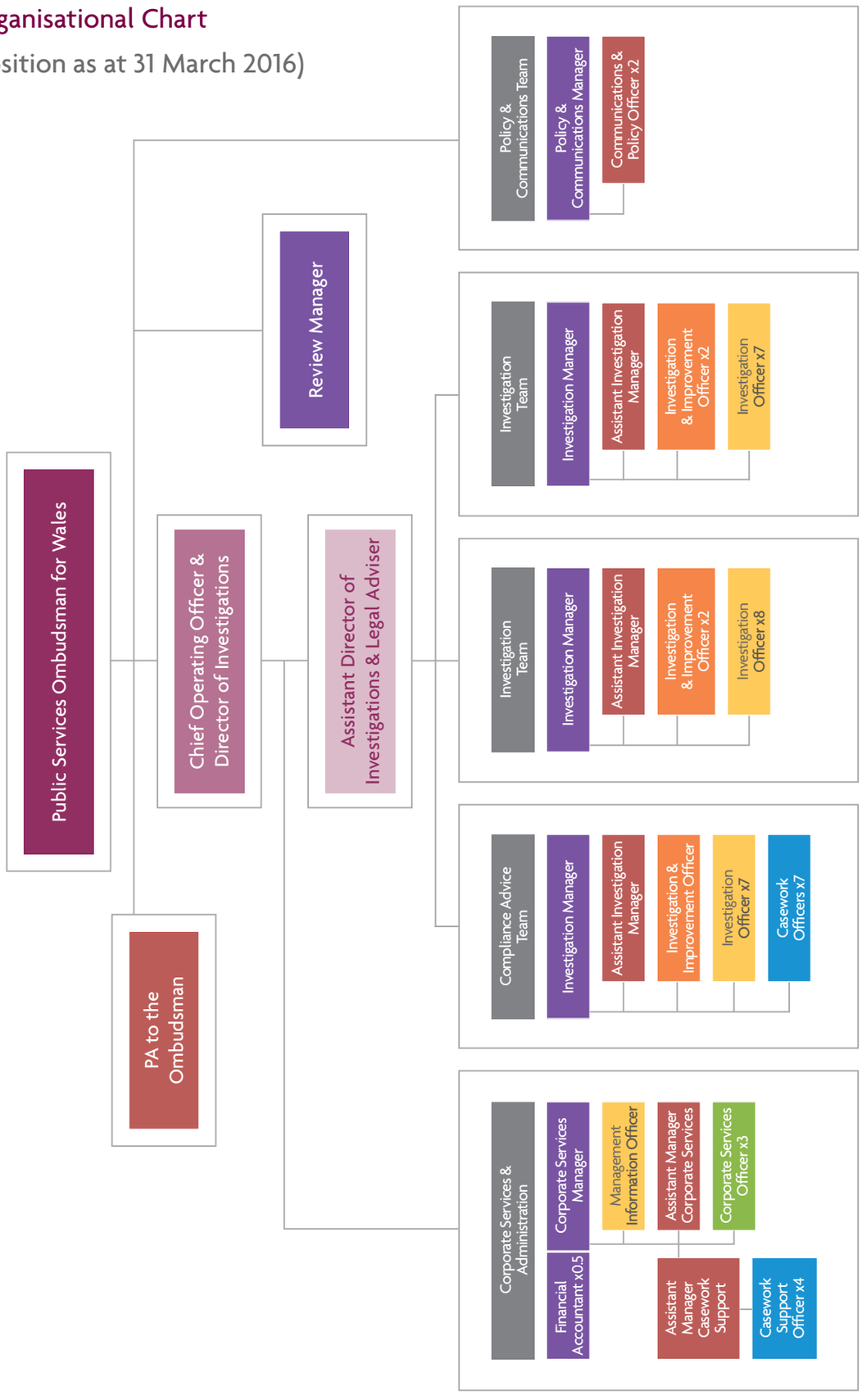


European Directive on Alternative Dispute Resolution

Last year I reported on the possible impact on the PSOW of the European Directive on Alternative Dispute Resolution and the Alternative Dispute Resolution for Consumer Disputes (Competent Authorities and Information) Regulations 2015 that the UK Government laid before Parliament on 17 March 2015. At the time of writing my report last year I was still considering whether or not it was appropriate for the PSOW to apply to be an ADR entity. For completeness, I now report here that I concluded that it was not appropriate for the PSOW to do so. Furthermore, since my decision, other UK public sector ombudsmen (and the Irish Ombudsman) have arrived at a similar conclusion.

Organisational Chart

(Position as at 31 March 2016)



7. Other Activities

Co-operation with Commissioners

I have been actively looking for opportunities to co-operate with other ombudsmen and commissioners in circumstances where this is appropriate. I have already reported on a publication I issued jointly with the Information Commissioner, and I am pleased that I can report on another two specific developments that have taken place over recent months:

- **Internal Audit Contract** – With the end of the PSOW's internal audit contract on the horizon, I was pleased that the Children's and Older People's Commissioners agreed that, with a view of achieving cost savings, it would be beneficial to procure on the basis of comprehensive internal audit tender process upon which each Commissioner's office could then draw upon individually. A successful tender process resulted to the satisfaction of both Commissioners and myself,

- **Future Generations Commissioner** – I also had very positive discussions with the new Future Generations Commissioner and was pleased to be able to agree to provide the Commissioner with a staff salaries service for her office.

In addition to the above, I have continued to meet regularly with the Commissioners in Wales to discuss issues of mutual interest.

Complainant satisfaction research

We have continued with our satisfaction survey practice in relation to customer satisfaction for our first contact service. The table below gives the outcome for 2015/16 as follows (some respondents did not answer every question; the 'no responses' have been disregarded in respect of the outcomes below):

	% of respondents answering either 'strongly agree' or 'agree'
It was easy to find out how to contact the Public Services Ombudsman for Wales	95%
The service I have received has been helpful and sensitive	88%
Staff were able to understand my complaint / The person that dealt with my query knew enough to be able to answer my questions	88%
I was given a clear explanation of what would happen to my query/complaint	89%
The service has provided what I expected of it	83%

Clearly, the above outcomes are very pleasing; not least against the background of the increased volume of work faced by the frontline service as discussed earlier in this report.

We have also been considering other ways of understanding various stakeholders' views of my service. Looking at good practice elsewhere in the ombudsman community, I have decided that we should establish a number of sounding boards in this regard. The first of these will comprise members of advice and advocacy bodies, particularly inviting those organisations who help complainants through the complaints process. I also intend forming sounding boards to gain feedback from other organisations, including members of bodies within my jurisdiction, to understand their perspective on the service provided by my office. I hope that the first of these will be in place at the end of the first quarter of 2016/17.

Communications

External:

- Media - A positive relationship with the media continued over the past year and meetings with a number of journalists, particularly broadcast journalists took place to discuss and explain matters of current concern and interest to the office. Once again a number of opportunities arose for me to give television and radio interviews. There was an excellent level of reporting on the 'Out of Hours: Time to Care' thematic report as well as on the public interest reports that I issued during the year.

- Website and Social Media – We have during the year been reviewing the PSOW website and our social media activity. As a result we further developed our social media presence by adding to the existing Twitter account by introducing a Facebook page and also creating a YouTube channel. We intend to commence work on revamping the website during 2016/17.

Internal: We have also enhanced and improved internal communication activities in the office. In particular a weekly bulletin is now being produced for staff which highlights press attention gained by the ombudsman's office, as well as articles in the press relevant to the work of the office. The bulletin is also used to share around the office briefings from various meetings that staff have attended. In addition to the bulletin a new version of the Magnifying Glass, the staff newsletter, has been introduced and this now appears in an online digital format.

The Ombudsman Community

Over the years, despite being a relatively small Ombudsman scheme compared to those of other countries, the PSOW has punched above its weight in relation to its position within the ombudsman community. PSOW officeholders have held senior offices at the OA (the British and Irish Ombudsman Association) and the International Ombudsman Institute.

I was delighted to be able to continue to carry the torch when, in May 2015, I was elected as the Vice Chair of the OA. An Ombudsman is pretty much a unique role and membership and participation within such organisations are important. This allows us to share best practice, learn from each other and indeed advance the ombudsman institution in light of external developments. Other members of my staff have also continued to participate in OA activities, including participating in a number of the OA Interest Groups.

Complaints about the PSOW service

We have over the past year also reviewed and revised our own complaints policy and procedure. That is the procedure for those people who want to complain about the service I provide. A key change is that I have decided to appoint an independent external reviewer of complaints about my service.

This review service is available to those who have complained to me about my service, but remain dissatisfied having received my response. It is not for the reviewer to 're-investigate' a complaint or review a decision taken by me (in respect of a complaint about a public service provider), but to consider the service my staff have provided bearing in mind the examples listed below. Following any review, I will then consider any recommendations or suggestions the reviewer may make.

I have taken this step with a view to taking further the developments of recent years in making the PSOW open to scrutiny and review; in this instance in respect of the handling of complaints about the PSOW service.

The policy can, for example, be used when complainants feel that we have:

- treated them unfairly or rudely; or
- failed to explain things clearly; or
- caused unreasonable delays; or
- failed to do what we have said we would; or
- failed to follow our processes correctly.

The policy for complaints about my service also accommodates the process for when someone wants to request an internal review by the PSOW of the decision on their complaint about a public service provider.

Further details about this policy is available on my website: www.ombudsman-wales.org.uk.

The table below reports on the number of complaints received during 2015/16 and their outcomes, together with a comparison of the position in 2014/15.

	2015/16	2014/15
Complaints brought forward from previous year	1	3
New complaints received	61	82
TOTAL COMPLAINTS	**62**	**85**

OUTCOMES		
Not upheld (service related issue)	20	14
Upheld in whole or in part	15	12
Related to investigation decision - referred to investigation process	18	44
Complaint withdrawn or insufficient information	9	14
Total closed during year	**62**	**84**
Ongoing and carried forward at 31 March	0	1

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

Undue delay in response / or delay in correspondence referral	4
Interview Digital Sound recording error	1
Incorrect information provided	1
Incorrect complainant title / salutation on correspondence	1
Internal records not updated in a timely manner	1
Incoming courier process error	1
Misfiling of correspondence	1
Correspondence sent in error	5
Total	**15**

The following corrective action was undertaken:

- an apology was issued to the complainant in all 15 cases
- the relevant line Manager(s) were made aware of the upheld complaints relevant to their team for future training and monitoring
- appropriate and relevant staff training was undertaken where necessary
- appropriate action in accordance with PSOW Human Resources policies was undertaken
- relevant policies / processes reviewed to minimise risk of re-occurrence.

Report on Independent Review of Complaints About the PSOW Service

Whilst the arrangement for independent external review of complaints about my services has been in place for less than a full year, a report has been prepared for the four months to 31 March 2016. Seven complaints were referred to the external reviewer, but none was accepted for review. One was premature, in two cases further advice was sought from the external reviewer and in the remaining four cases the complaint was about my decision on their complaint about a public service provider, rather than about the service provided by my staff. The independent external reviewer made two recommendations: that I provide greater clarity about the role and limits of internal complaints and review processes, and possible routes, at the beginning of the process, and that I add further details of the limitations of the independent external review service to my responses to complaints about the services I and my staff provide. Both recommendations will be implemented.

8. Annual Equality Report

Under the Equality Act 2010 and the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 laid down by the National Assembly for Wales, the Ombudsman is required to produce an annual report in respect of equality matters. I do so here as part of my overall Annual Report for 2015/16.

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

Accessibility

As part of our process, we do our very best to identify as early as possible any individual requirements that may need to be met so that a service user can fully access our services and, in particular, we ask people to tell us their preferred method of communication with us.

During 2015/16, we gave particular focus to improving access to our service for people who are deaf or hard of hearing. A new British Sign Language (BSL) video is now available, which explains the Ombudsman's service, as well as how people who are deaf or hard of hearing can access that service. Subtitles in both English and Welsh also make the video accessible to those with hearing loss who are unable to understand BSL. This coincides with the provision of the new SignVideo interpretation service which allows BSL users to contact the Ombudsman for free, using fully-qualified live interpreters. Calls can be made using a videophone, laptop, PC, tablet or smartphone enabling BSL users to have improved access to the Ombudsman's services.

We have always tried to make reasonable adjustments where these will help people make and present their complaint to us. Well established examples are: providing correspondence in Easy Read; using Language Line for interpretation, where a complainant is not comfortable with making their complaint in English or Welsh; obtaining expertise to assist us to understand the particular requirements of complainants with certain conditions, such as Asperger's syndrome; and visiting complainants at their homes.

We produce key documents in alternative formats, such as CD/tape and Braille, and translate these into the eight key ethnic minority languages used in Wales. Our website has continually been developed from initially being upgraded A to AA compliant, and then other introductions such as: enhanced BrowseAloud service; embedding the GoogleTranslate service meaning that the PSOW website content pages are automatically translated into any one of over 100 languages on selection; and, most recently, the BSL video referred to above.

The Complaints Advice Team also continues to provide information on advocacy and advice organisations to those people who may need assistance in making their complaint to me. This information is also readily available on our website.

Equality Data Gathering/Monitoring – Service Users

We continued with our equality monitoring in respect of service users, which informs our annual outreach strategy. The outcome of the monitoring during 2015/16 in respect of the protected characteristic groups (as defined in the Equality Act) is set out below.

In view of the nature of the work of this office, we would expect the people who complain to me to, at the very least, mirror the national demographic position; in fact, we would expect the proportion of complainants from groups who could be considered to be at disadvantage or vulnerable to exceed the national picture. In respect of each of the questions we asked, those who completed the form were given the opportunity to respond 'Prefer not to say'.

The results below are not dissimilar to those of previous years and similarly I am relatively satisfied that in making comparisons with official data available (e.g. the Census 2011) the composition of our service users meets or exceeds national demographics in the way we would expect. This office has previously identified an area that appeared to be slightly underrepresented was the minority ethnic community. Progress had been made whereby we were matching the demographic (4% of the Welsh population according to the Census). However it is really good to see , from an awareness point of view, that of those who completed the equality monitoring form during 2015/16, 6% identified themselves as being from a minority ethnic background.

Protected characteristic group	Percentage Outcome
Age	
Under 25	3%
25-34	11%
35-44	20%
45-54	23%
55-64	22%
65-74	11%
75 or over	5%
Prefer not to say/No response	5%
Disability	
Yes	25%
No	64%
Prefer not to say/No response	11%
Health problem or disability limiting day-to-day activities?	
Yes, limited a lot	24%
Yes, limited a little	12%
No	53%
Prefer not to say/No response	11%
Gender reassignment	
Yes	0.5%
No	23%
Prefer not to say/No response	76.5%
Religion or belief	
No religion	40%
Christian (all denominations)	47%
Other religions	8%
Prefer not to say/No response	5%
Married or same-sex civil partnership	
Yes	47%
No	41%
Prefer not to say/No response	12%
Race/Ethnicity	
White	88%
Other ethnic background	6%
Prefer not to say/No response	6%
Sex	
Male	50%
Female	45%
Prefer not to say/ No response	5%
Sexual orientation	
Heterosexual or straight	84%
Gay or Lesbian	1%
Bisexual	1%
Other	1%
Prefer not to say/No response	13%

Outreach

We take the results from our equality monitoring into account when developing our outreach programmes. We gave focus to two areas in particular during 2015/16: older people and people who are deaf or hard of hearing. With both equality and accessibility considerations in mind, we have also been giving attention to poverty/social exclusion as our research has indicated that awareness of the Ombudsman is low amongst this part of the Welsh population.

As part of this work my staff and I have engaged with the Wales Council for Voluntary Action; Tenant Participation Advisory Service, Shelter Cymru and I also chaired a meeting between the Welsh Government's Minister for Communities and Tackling Poverty, Michael Sheen (actor and campaigner) and housing charities in relation to youth homelessness. We have also engaged with organisations such as Action on Hearing Loss; Age Cymru and others.

Complaints Wales Signposting Service

I also view the Complaints Wales signposting service as important in relation to the office's contribution to the equality duty. This is an independent and impartial service delivered by the Complaints Advice Team to inform people where and how to put a complaint about a public service that provides the service they wish to complain about or to the appropriate independent complaint handler or ombudsman. I believe this to be an important service for those people who do not understand, are unfamiliar with, or feel disenfranchised from 'the public service system'. Promotion of the service continued during 2015/16, on this occasion through local/regional newspaper advertisements (both print and their associated online presence).

Our Casework

Our commitment and contribution to equality matters also manifests itself in our complaint handling work. We also have regard to matters of human rights. Whilst it is not for the Ombudsman to decide whether a public service provider is in breach of such legislation, it is possible that the failure to take account of any such legal obligations, or to follow policies and procedures designed to implement these obligations, will be maladministration. For example, following the investigation during the past year into a complaint about a homeless person, who was disabled and suffered from a post traumatic stress disorder, amongst other failings, I found that the time taken by the Authority to consider Mr A's housing application was out of kilter with the aims of the Equality Act. I made a number of recommendations. These included providing appropriate training for staff and ensuring that the special housing needs form and occupational therapy assessment processes are included in the Equality Impact Assessment tool to be used in Authority's new Allocation Scheme.

Training

We continue to provide relevant training to staff in relation to equality and human rights issues. I consider this important in relation to the service we provide to complainants, but also so that my staff are able to identify during our investigations any failings by public service providers in respect of their equality duties (as illustrated in a case example above). In particular, during 2015/16 I was grateful to members of the offices of the Northern Ireland Ombudsman and Northern Ireland Human Rights Commission for providing training to my staff on a manual they had jointly developed. The manual and the associated training will assist my staff in using a human rights-based approach in the decision to accept a complaint as well as investigating and reporting on the investigation.

Staff Equality Data Gathering/Monitoring

Our staff have been asked to complete and return a monitoring form seeking information in respect of each of the protected characteristics. We also now gather such information during our recruitment exercises. That disclosure is, of course, on a voluntary basis. The data held at 31 March 2016 is set out below.

Age	The composition of staff ages is as follows: 21 to 30: 17% 31 to 40: 29% 41 to 50: 31% 51 to 65: 23%
Disability	88% of staff said there were not disabled, no member of staff said that they were a disabled person (12% preferred not to say) However, when asked if their day-to-day activities were limited because of a health problem or disability which had lasted, or was expected to last, at least 12 months, 2% said that they were limited a lot, 2% said they were limited a little, 84% said their day to day activities were not limited (12% preferred not to say)
Nationality	In describing their nationality, 53% said they were Welsh; 25% said British, 10% said they were English, 2% said 'Other' (10% preferred not to say)
Ethnic group	The ethnicity of staff is: 81% White (Welsh, English, Scottish, Northern Irish, British); 2% White/Irish 3% Black (African, Caribbean, or Black British/Caribbean 2% Asian or Arian British/Bangladeshi (12% preferred not to say)
Language	When asked about the main language of their household, 73% of staff said this was English; 13% said Welsh, and 2% said 'Other' (12% preferred not to say)

Religion or Belief	Responses to the question asking staff about their religion were as follows: No religion: 39%; Christian 39%; Muslim 2%; Other:1% (19% preferred not to say)
Marriage/ Civil Partnership	When asked if they were married or in a same sex civil partnership, 49% of staff replied 'Yes'; whilst 32% said 'No' (19% preferred not to say)
Sexual Orientation	Responding on this, 75% said that they were Heterosexual or Straight, 2% said Gay or Lesbian (23% preferred not to say)

Under the specific duties we are required to set an equality objective for gender and pay; if we do not do so, we must explain why. I currently do not have any specific objective in this regard because females are very well represented at the higher pay scales within my office. The position is kept under continual review and the equality objectives will be revised if necessary. The table below shows the current the position.

Pay and Gender - data as of 31/03/2016

Pay (FTE)	**Male**	**Female**
Up to £20,000	1	4
£20,001 to £30,000	1	14
£30,001 to £40,000	2	4
£40,001 to £50,000	7	18
£50,001 to £60,000	4	3
£60,001 +	1	1
Subtotal	**16**	**44**
Total	**60**	

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

- 12 members of staff work part time (10 female, 2 male).
- 2 members of staff were employed on a fixed term contract.

Recruitment

During the past year we have had six members of staff leave. Seven new employees were recruited, five of these were to fill vacant posts and two were for the newly created positions of Communications & Policy Officers. Due to the low numbers involved, the equality data for the individuals appointed has been reported as part of the all staff information above; it is not considered appropriate to report separate equality information relating to these individuals due to the risk of identification

Equality data gathered from all of the past year's four recruitment exercises are as follows (note: totals showing 101% or 99% are a result of rounding):

Key

- **CWSO** – Casework Support Officer
- **PCO** – Policy and Communications Officer
- **IO/CO** – Investigation Officer and Casework Officer – joint recruitment panel.
- **APM** – Advisory Panel Member

		CWSO	PCO	IO/CO	APM	Total
Age	Did not say	3%	0%	6%	6%	4%
	under 25	34%	20%	28%	0%	21%
	25-34	36%	42%	35%	6%	30%
	35-44	18%	14%	21%	12%	16%
	45-54	8%	18%	10%	6%	11%
	55-64	1%	6%	0%	59%	17%
	65-74	0%	0%	0%	12%	3%
	75 and over	0%	0%	0%	0%	0%
		100%	100%	100%	101%	100%
Gender	Did not say	4%	0%	2%	0%	2%
	Male	32%	38%	42%	65%	44%
	Female	64%	62%	56%	35%	54%
		100%	100%	100%	100%	100%
Nationality	Did not say	1%	0%	3%	0%	1%
	Welsh	68%	64%	63%	35%	58%
	English	5%	6%	9%	6%	7%
	Scottish	1%	2%	3%	0%	2%
	Northern Irish	1%	0%	1%	6%	2%
	British	23%	27%	18%	53%	30%
	Irish	1%	0%	3%	0%	1%
		100%	99%	100%	100%	100%

		CWSO	PCO	IO/CO	APM	Total
Ethnic Group	Did not Say	3%	2%	8%	0%	3%
	White (Welsh/ Scottish/English/ NI/British)	93%	95%	81%	88%	89%
	White (Irish)	1%	2%	2%	6%	3%
	White (Gypsy/Irish traveller)	0%	0%	0%	0%	0%
	White (Other)	0%	0%	0%	6%	2%
	Asian /Asian British	2%	2%	6%	0%	3%
	Black, African, Caribbean or Black British	0%	0%	3%	0%	1%
	Mixed or multiple ethnic group	1%	0%	0%	0%	0%
	Other ethnic Group	0%	0%	0%	0%	0%
		100%	101%	100%	100%	100%
Language	Did not say	2%	0%	2%	0%	1%
	English	95%	94%	93%	94%	94%
	Welsh	0%	0%	0%	0%	0%
	Bilingual (Welsh / English)	3%	6%	5%	6%	5%
	Other	0%	0%	0%	0%	0%
		100%	100%	100%	100%	100%
Disability	Did not say	2%	2%	3%	0%	2%
	Yes	2%	2%	1%	6%	3%
	No	97%	97%	96%	94%	96%
		101%	101%	100%	100%	101%
Limited Activities	Did not say	2%	2%	3%	0%	2%
	Yes, limited a little	1%	0%	0%	0%	0%
	Yes, limited a lot	0%	0%	0%	0%	0%
	No	97%	98%	97%	100%	98%
		100%	100%	100%	100%	100%

		CWSO	PCO	IO/CO	APM	Total
Religion	Did not say	7%	6%	12%	0%	6%
	None	64%	61%	59%	12%	49%
	Christian	29%	32%	29%	88%	45%
	Buddjist	0%	0%	0%	0%	0%
	Hindu	0%	0%	0%	0%	0%
	Jewish	0%	2%	0%	0%	1%
	Muslim	0%	0%	0%	0%	0%
	Sikh	0%	0%	0%	0%	0%
	other	0%	0%	0%	0%	0%
		100%	101%	0%	0%	50%
Married or civil partnership	Did not say	5%	0%	7%	12%	6%
	Yes	12%	35%	16%	71%	34%
	No	83%	64%	77%	18%	61%
		100%	99%	100%	101%	100%
Sexuality	Did not say	15%	2%	19%	0%	9%
	Heterosexual	77%	89%	74%	100%	85%
	Gay or Lesbian	6%	5%	7%	0%	5%
	Bisexual	2%	5%	0%	0%	2%
	Other	0%	0%	0%	0%	0%
		100%	101%	100%	100%	100%

*excludes internal promotion

Staff Training

The majority of staff training is based upon job roles or applicable for all staff to attend, and as such there are no equality considerations to report. All individually requested training by staff has been approved, and as such there is no need to report on equality data differences between approved and non-approved training requests.

Disciplinary / Grievance

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

Procurement

Our procurement policy now refers to the relevant equality requirements that we expect our suppliers to have in place.

Annex A

Public Body Complaints

Public Interest Reports: Case Summaries

Health

Abertawe Bro Morgannwg UHB – Issued March 2016 – Case Ref 201501032

Miss X said that her brother, Mr X, suffered from a congenital heart defect ("ACHD") and had surgically treated kyphoscoliosis (a condition in which the spinal column is convex both backward and sideways). She complained about the insufficient regularity of investigations, notably Echocardiagrams (a diagnostic test that uses ultrasound waves to make images of the heart chambers, valves and surrounding structures) ("ECHOs"), leading up to October 2011. She said that if ECHOs had been carried out every six months, treating clinicians might have detected a sub aortic membrane (a form of fixed sub aortic obstruction in which a fibrous membrane is located below the aortic valve) earlier than January 2012.

Miss X also complained that her brother could not be put on the waiting list for surgery until all tests and investigations had been completed and this took 11 months. She said that her brother should have been given priority due to his kyphscoliosis and the effect this had on his ability to expand his lungs. Miss X said that this would not have been an issue had the investigative tests been undertaken within a reasonable time. She said that the failure to undertake ECHOs far more frequently and to undertake investigative tests within a reasonable time meant that her brother did not receive surgery in time to save his life. Mr X was 57 years old when he passed away.

I concluded that there was no evidence to suggest that ECHO tests should have been undertaken more frequently. This was in light of the fact that the degree of obstruction caused by Mr X's sub aortic membrane (the narrowing of the left ventricle of the heart just below the aortic valve through which blood must pass) would have been unlikely to have been detected earlier than January 2012, which prompted the need for surgery. Given that there was no significant deterioration in Mr X's condition between October 2011 and December 2012, I found no failing in the level of priority that the Health Board gave Mr X for surgery. I upheld the complaint about the clinical advice given to Mr X during his wait for surgery. There was no evidence that Mr X was made aware of worrying symptoms. I upheld the complaint regarding Mr X's wait for treatment.

Treatment should have been supplied within 26 weeks, but Mr X was not due to receive treatment until 50 weeks had elapsed. Had Mr X received surgery more promptly, on the balance of probabilities, his death would have been avoided. I therefore took the view that Mr X's death was avoidable.

I made the following recommendations:

(a) that the Health Board's Chief Executive personally apologises to Miss X for the failings identified in my report, most notably, Mr X's avoidable death.

(b) that the Health Board concludes its "mirror" process to that conducted under the "Putting Things Right" ("PTR") in order to assess the level of compensation that it should offer to Mrs X in respect of the avoidable death of Mr X. The Health Board has confirmed that the file has already been shared with its legal department for this purpose and, with that in mind, it should conclude this process within three months of the date of issue of the report.

(c) that the Health Board ensures that the British Heart Foundation leaflet entitled 'Heart Valve Disease' is given to every relevant patient at clinic and that the checklist is completed to reflect this, and that appropriate advice has been given. The Health Board should ensure that all Cardiology clinicians are aware of this requirement. Confirmation that all relevant clinicians are aware of the leaflet, have sufficient copies and are aware when it should be used, should be provided to my office within two months of the date of the report.

The Health Board agreed to implement the recommendations.

Betsi Cadwaladr UHB - Issued October 2015 – Case Ref 201405067

Mrs P complained about her late husband Mr P's treatment in what were his final weeks and about the handling of her complaint. Specifically, she complained about a delay in Mr P being seen on admission to hospital due to a bed shortage, a failure in diagnosing his brain cancer from a scan performed, and failures in his care and treatment (including being given a drug of limited prognostic benefit). Mrs P also complained about how Mr P was afterwards discharged home to her care without appropriate plans and services in place. She further complained about his discharge with medication (about which no advice or guidance had been offered) and also about a letter written to her by the Consultant treating Mr P after his death, which had caused her further distress.

Following an examination of clinical records, and advice from my clinical advisers, the following aspects of the complaint were not upheld: Whilst Mr P's brain cancer had not been diagnosed from the scan this was within acceptable clinical practice on the part of an average radiologist, given the type of cancer was rare. However, given Mr P's ongoing symptoms, consideration should have been given to a second opinion from a Neuroradiologist. Whilst recognising Mrs P's distress in receiving the letter, at an emotional time, the Consultant had written it with the best of intentions. It was not, to the objective eye, insensitive or meant to cause her distress.

The following complaints were upheld: There had been a delay in Mr P's admission. The course of clinical treatment offered to Mr P at that stage of his illness was not reasonable (given its slow response rate) in comparison with a treatment he could have been offered which may have prolonged his life expectancy even for a short time. Mr P was discharged home without proper arrangements in place. The discharge lacked effective communication with both Mr and Mrs P, and raised serious concerns surrounding controlled medication. The complaint handling concern was also upheld.

The following recommendations were made, all of which the Health Board agreed to implement in full:

(a) a written apology to Mrs P and an offer of redress of £3,000 for her distress, time and trouble in pursuing her grievances and complaint handling delays;

(b) the preparation of an action plan dealing with the nursing care failings identified by my clinical adviser (relating to clinical care, patient discharge and record keeping);

(c) the case should be discussed at both Radiology and Cancer services meetings as a learning point, taking into account the critical comments of my clinical advisers. An action plan to deal with resulting actions to avoid recurrence should be prepared and shared with me.

Cardiff & Vale UHB – Issued June 2015 – Case Ref 201401302

Dr A complained about the care given to his mother ("Mrs A") by Cardiff and Vale University Health Board ("the Health Board"). He said that, on 13 February 2014, Mrs A was admitted to the Medical Assessment Unit ("the MAU") of the University Hospital of Wales. She was later transferred to a surgical ward ("the Ward"). Dr A said Mrs A was triaged wrongly, the medical team were late in examining her and no treatment was given. He said the MAU misdiagnosed and mismanaged sepsis and failed to follow the "sepsis pathway". He also said:

- antibiotics were either administered late or not at all;
- fluid balance monitoring was not done. His mother was septic and was unable to pass urine, but a catheter was not inserted;
- no paracetamol was given in the MAU and she remained feverish throughout her stay in the MAU;
- despite being on oxygen when she was in the MAU, she was not given oxygen during a transfer between the MAU and the Ward.

Dr A said the failings led to Mrs A suffering a cardiac arrest on 13 February. Mrs A remained in hospital until 8 March when, sadly, she died.

My investigation considered the relevant records along with comments from the Health Board and Dr A. I also obtained advice from two of my clinical advisers.

Sepsis is a common and potentially life-threatening condition triggered by an infection. If not treated quickly, it can eventually lead to multiple organ failure and death. Early symptoms of sepsis usually develop quickly and it can move from a mild illness to a serious one very quickly. Therefore, early intervention is key. If identified and treated quickly, sepsis is treatable. The Sepsis Six is a recognised set of interventions (including the giving of antibiotics) which, when delivered in the first hour, can increase the chance of survival.

My investigation found that Mrs A was suffering from sepsis. However, the Health Board failed to implement the Sepsis Six.

Mrs A should have been seen by a doctor within 10 minutes of triage; however she was not reviewed by the doctor for three and a half hours. There was a similar delay in the giving of paracetamol and, more seriously, a delay of over six hours in the giving of antibiotics.

My investigation also found that the Health Board failed to follow record keeping and complaint handling guidance.

In relation to Dr A's complaint that Mrs A was not given oxygen during a transfer between the MAU and the Ward, it is clear that Mrs A needed supplementary oxygen and this was given in the MAU. However, it was not clear from the records whether this was provided during the transfer to the Ward. If Mrs A was transferred without oxygen this would be a serious failing. The records indicated that she was peripherally cyanosed shortly after the transfer. This fits with the possibility that she was transferred without oxygen. She then suffered a cardiac arrest.

Unfortunately, as a result of poor record keeping, my investigation could not determine with any certainty whether Mrs A was, or was not, given oxygen during the transfer. Nor could it definitively identify what role the transfer played in her suffering a cardiac arrest. The poor record keeping therefore caused uncertainty which is an injustice.

I concluded that the care provided to Mrs A on 13 February was inadequate. Therefore, I upheld Dr A's complaint and recommended that the Health Board should:

(a) give Dr A an unequivocal written apology for the failures identified by this report

(b) make a payment to Dr A of £4,000 to reflect the:
  i. distress caused by the failings in Mrs A's care;
  ii. uncertainty caused by those failings;
  iii. failings in the Health Board's handling of his complaint;
  iv. provision of incorrect information during the complaint process

(c) so that appropriate lessons may be learned, share this report with the doctors, nurses and administrative staff involved in the case

(d) formally remind the doctors and nurses involved in Mrs A's care to follow the relevant record keeping guidance. (If needed, and within four months of the date of this report, the Health Board should implement refresher training for staff, involved in the case, who indicate that they are not fully conversant with the relevant guidance)

(e) provide me with evidence of its current process which ensures that doctors and nurses who meet with complainants are familiar with the case and the patient's records

(f) provide me with evidence of the existing monitoring and quality assurance mechanisms it has in place to prevent a recurrence of the failure of:

i. doctors to review a patient categorised as triage 2 within the timescales specified by the MTS
ii. doctors and nurses to follow the sepsis pathway
iii. doctors to ensure that the surgical review was performed by a doctor experienced enough to perform it
iv. doctors and nurses to maintain appropriate records
v. doctors, nurses and administrative staff to follow the Complaints Guidance.

(If the Health Board is not able to provide evidence to show that it has current suitable protocols for (e) and (f)(i) – (v) then, within four months, it should provide its plans to introduce such protocols.)

(g) ensure that staff training in respect of recognising sepsis is up to date.

(If needed, and within six months of the date of the investigation report, the Health Board should implement training for staff who indicated that they were not fully conversant with the relevant protocols.)

Hywel Dda UHB & Welsh Ambulance Service Trust - Issued June 2015 – Case Refs 201400661 & 201402833

Mrs X complained about the care and treatment her late husband received from Hywel Dda University Health Board's ("the Health Board") out of hours service ("OOH") and Welsh Ambulance NHS Trust ("WAST") during the final stages of his life.

The investigation found that the Health Board had failed to ensure that there would be any OOH GP cover in the Pembrokeshire area on 15 July 2013. As a result of that failing Mr X had to wait three hours to be seen by a doctor, which is a significant period when experiencing pain and anxiety, particularly in the final hours of life. The failure to ensure adequate cover was in place put additional strain on the emergency services and placed the residents of Pembrokeshire at risk.

The investigation also found that following Mr X's sad death, the paramedic in attendance did not understand his responsibility under the "Recognition of Life Extinct" ("ROLE") policy which resulted in an unnecessary decision to call the Police. It was also noted that in response to Mrs X's complaint about this matter WAST endorsed the actions of the paramedic despite those actions being contrary to the ROLE policy.

I recommended that the Health Board apologise to Mrs X and her family and pay the sum of £1,000 in recognition of the distress and injustice arising from the identified service failure. I also recommended that the Health Board remind GPs of the need to ensure that a patient's

computerised "special notes" are completed and accessible by the OOH service and that "Just in Case Boxes" contain the necessary prescriptions. Finally, I recommended that the Health Board review its contingency plan for periods where there are no GPs available in the area and ensure that the OOH practitioners available have the necessary skills.

I recommended that WAST apologise to Mrs X and her family and pay the sum of £500 in recognition of the distress and injustice arising from the identified service failure. It was also recommended that paramedics and officers are reminded of their responsibilities under the ROLE policy and the Code of Practice. Finally it was recommended that WAST review its training plan to include training on the ROLE policy.

Education

Wrexham County Borough Council – Issued February 2016 – Case Ref 201403532

Mrs A complained that Wrexham County Borough Council ("the Council"), in its role as the local education authority ("LEA") failed to properly consider, assess and identify her son, B's, special educational needs ("SEN"). Mrs A said the LEA failed to consider whether B's SEN would be better provided for by a statutory assessment. Mrs A considered that the Extended School Action Plus Agreement ("ESAP") issued by the LEA for B was not monitored and the LEA failed to ensure that his school provided the support specified under that Agreement. Mrs A complained that the Council failed to properly handle her complaint about the LEA.

The investigation found that ESAP Agreements are not referred to, or recognised, either as part of a graduated approach or as an alternative to statutory assessment in any of the LEA's information, procedures and/or its published policies for SEN provision. I concluded that in B's case an ESAP Agreement, as an alternative to statutory assessment, was not a legitimate means of meeting B's SEN. The LEA's policy was clear when B's school based interventions were insufficient to meet his SEN requirements, B should have been considered for a statutory assessment. I was concerned about the LEA's use of ESAP Agreements as an alternative to statutory assessment.

The LEA argued that B's ESAP Agreement was on a par with an SEN Statement but the investigation concluded this was not the case. Further, the ESAP Agreement issued by the LEA was only in place for a two week period during which B attended school on significantly reduced hours. As such the ESAP provision was not met by the LEA.

I upheld Mrs A's complaint and concluded that the LEA failed to assess and identify B's SEN and failed to provide B with the appropriate support to meet his identified needs. I upheld

Mrs A's complaint about the way the Council handled her complaint, although the Council had subsequently made changes to its complaint management procedure to avoid a recurrence of the situation.

I recommended the Council apologise to Mrs A and provide redress of £350 for Mrs A's time and trouble in pursuing a complaint. It was also recommended that the Council identify and instruct an independent educational specialist to review educational provision to B; the Council review it's published SEN Policy; and the Council audit the ESAP Agreements currently in place to consider whether statutory assessments should be carried out in accordance with its SEN Policy.

Other

Cynwyd Community Council – Issued November 2015 – Case Ref 201403092

Mrs X complained about poor communications that the Council had with local residents. Mrs X said that it posted some notices in Welsh only and she was aggrieved that this excluded her from becoming involved with the Council as she does not speak Welsh. She said that, when the Council posted agendas in Welsh only, non-Welsh speakers were being disadvantaged because they did not know what would be discussed at those meetings.

Mrs X considered that the Council's meetings being held solely through the medium of Welsh also excluded her, because she would not understand what was being discussed. She felt that the way that the Council conducted its business detrimentally affected her ability to properly take part in local democracy.

Mrs X considered that the Council should ensure that all of its notices and meetings should be bilingual so that everyone could be involved and made to feel that their views and concerns were equally valid.

Whilst I fully accept and support the principle that the Council has a right to conduct its business through the medium of Welsh, I found that by posting agendas in Welsh only the Council had failed to make adequate written bilingual provision for Mrs X as a person who understands English, but not Welsh. That amounted to maladministration which caused Mrs X to suffer an injustice. I therefore upheld Mrs X's complaint. I recommended that:

(a) the Council apologise to Mrs X in writing for failing to make adequate written bilingual provision for her;

(b) the Council undertake to publish all agendas bilingually and to make other documents available bilingually (including meeting minutes if they were not already available bilingually) where reasonably practicable to do so.

The Council did not accept the findings of the report and refused to implement the recommendations made.

I had also recommended in an earlier draft of this report that the Council should make a payment of £100 to Mrs X in recognition of the time and trouble she had expended pursuing her complaint. Mrs X, having seen the draft, said that she was disinclined to accept the money. I therefore did not ask the Council to make such a payment to Mrs X, although I considered it would be merited.

[Note: Subsequent to the publication of the above report, the Community Council met and agreed to implement my recommendation at (b) above.]

Annex B

Public Body Complaints:
Statistical Breakdown of Outcomes by Public Body

Note: Complaints included in the category 'Other cases closed after initial consideration' on the pages which follow, consists of those received which:

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

County/County Borough Councils

County/ County Borough Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Blaenau Gwent	3	8	5	1	1		1			**19**
Bridgend	4	18	17		1				2	**42**
Caerphilly	10	17	24		2		1	1	1	**56**
Cardiff	15	46	58		20		2	1	1	**143**
Carmarthenshire	8	12	18		8		2	3		**51**
Ceredigion	7	12	6	1	5		2			**33**
Conwy	3	5	10		2					**20**
Denbighshire	7	10	17	2	1		2	1	1	**41**
Flintshire	4	18	14		2		3			**41**
Gwynedd	7	4	11	1	4		1	1		**29**
Isle of Anglesey	2	14	12				4	1		**33**
Merthyr Tydfil	1	5	5	1	4				1	**17**
Monmouthshire	7	7	9				1			**24**
Neath Port Talbot	5	14	16		1			1	1	**38**
Newport	1	10	14	1	4		1	4		**35**
Pembrokeshire	6	17	17		4		1		1	**46**
Powys	13	20	16		5		7	1	1	**63**
Rhondda Cynon Taf	9	11	19		3					**42**
Swansea	12	9	19		2		1		1	**44**
Torfaen	2	4	9		1			1		**17**
Vale of Glamorgan	6	14	19		3					**42**
Wrexham	6	17	21		8	1	2		1	**56**
Total	138	292	356	7	81	1	31	15	11	**932**

Other Local Authority

School Appeal Panels	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Croesty Primary School			1							**1**
Cardiff High School			1							**1**
All Saints Church in Wales Primary School - Admissions Authority							1			**1**
All Saints Church in Wales Primary School - Appeal Panel							1			**1**
Beaufort Hill Primary			1							**1**
Mary Immaculate Catholic High School			1							**1**
Rogerstone Primary School			2							**2**
Rumney Primary School			1							**1**
Ysgol Gynradd Llanelltyd			1							**1**
Ysgol Gyfun Gymraeg Plasmawr			1							**1**
Bishopston Comprehensive School			1							**1**
Fitzalan High School			1							**1**
Penarlag Primary School								1		**1**
Mount Stuart Primary School			1							**1**
Total			12				2	1		**15**

Other Local Authority (Continued)

National Park Authority	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Brecon Beacon	1	1	3		1					**6**
Pembrokeshire Coast		1	2		1					**4**
Total	1	2	5		2					**10**

Fire & Rescue	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Mid and West Wales			1							**1**
South Wales	1									**1**
Total	1		1							**2**

Community/Town Councils

Community or Town Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abergavenny Town			1							**1**
Aberystwyth Town	1									**1**
Bangor City		1								**1**
Cornelly Community		1								**1**
Corris Community			1							**1**
Cwmamman Town		1								**1**
Cynwyd Community						1				**1**
Glynneath Town	1	2								**3**
Holyhead Town	2									**2**
Llanddew Community		1								**1**
Llanfynydd Community [Carmarthenshire]			1							**1**
Llangattock Community			1							**1**
Llantwit Fardre Community		1								**1**
Llywel Community			1							**1**
Neath Town		1	6							**7**
Raglan Community							1			**1**
Rhosllanerchrugog Community		1								**1**
Sully and Lavernock Community	1									**1**
Trefeglwys Community	1									**1**
Welsh St Donats Community			1							**1**
Ynysawdre Community	1	1								**2**
Total	7	10	12			1	1			**31**

Registered Social Landlords

Housing Association (Registered Social Landlord)	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abbeyfield, South Wales Society	1									**1**
Bro Myrddin			2							**2**
Bron Afon Community Housing Ltd	1	3	1							**5**
Cadarn Housing Group Ltd		1								**1**
Cadwyn Housing Association Ltd		1	2							**3**
Cardiff Community			1		1				2	**4**
Cartrefi Conwy		3	1							**4**
Cartrefi Cymunedol Gwynedd	2	3	10		2				1	**18**
Charter Housing		4	4							**8**
Clwyd Alyn	2		4		3					**9**
Coastal Housing Group Ltd		1								**1**
Cymdeithas Tai Cantref							1			**1**
Cynon Taf Community Housing		1								**1**
Derwen Cymru					2					**2**
Family Housing Association (Wales) Ltd		1								**1**
First Choice Housing Association Ltd		1								**1**
Grwp Cynefin			1							**1**
Grwp Gwalia Cyf Ltd	2	1	6		1					**10**

Registered Social Landlords (Continued)

Housing Association (Registered Social Landlord)	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Hafod	1	2	5							**8**
Hendre		1								**1**
Linc-Cymru		2			2					**4**
Melin Homes Ltd		2	2							**4**
Merthyr Tydfil Housing Association Ltd		1								**1**
Merthyr Valleys Homes	2	1	2						1	**6**
Mid Wales Housing Association Ltd	2				1					**3**
Monmouthshire		2								**2**
Newport City Homes		3	4		1					**8**
Newydd			1							**1**
North Wales Housing		2	1		1					**4**
NPT Homes	2	5	7							**14**
Pembrokeshire Housing Association Ltd	1	1	2							**4**
RCT Homes		4	2							**6**
Rhondda Housing Association Ltd	1	1							1	**3**
Tai Calon		1								**1**
Tai Ceredigion Cyf	1	1	2							**4**
United Welsh		3	1		1					**5**
Valleys To Coast		1	1		1					**3**
Wales and West	1	3	3							**7**
Total	19	56	65		16		1		5	**162**

Local Health Boards and NHS Trusts

Local Health Board/ NHS Trust	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abertawe Bro Morgannwg	15	21	33	2	12	1	16	10	5	**115**
Aneurin Bevan	9	15	28		12		21	9	3	**97**
Betsi Cadwaladr	11	27	40		24	1	21	8	3	**135**
Cardiff and Vale	7	17	22		14	1	16	5	3	**85**
Cwm Taf	4	12	18		12		11	10		**67**
Hywel Dda	7	27	18	1	32	1	14	1	1	**102**
Powys Teaching	3	3	17	1	6			9	1	**40**
Public Health Wales		1	1		1					**3**
Velindre	1						1			**2**
Welsh Ambulance Services	3	4	6			1	2			**16**
Total	60	127	183	4	113	5	102	52	16	**662**

Other Health Bodies

Other Health	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Dentists		11	7		5		3	2	4	**32**
GPs	7	26	29	5	2		16	31	1	**117**
Pharmacist					1			1		**2**
Total	7	37	36	5	8		19	34	5	**151**

Welsh Government and Welsh Government Sponsored Bodies

Welsh Government and Welsh Government Sponsored Bodies	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Welsh Government										
CAFCASS Cymru		2	4		1		1			**8**
CSSIW			3		1		1	1		**6**
Healthcare Inspectorate Wales					1					**1**
Independent Complaints Secretariat	1									**1**
Planning Inspectorate			5				1			**6**
Welsh Government	4	7	6	1	3		1	1		**23**
Welsh Health Specialised Services Committee		1	3							**4**
Total	5	10	21	1	6		4	2		**49**

Welsh Government Sponsored Body										
Higher Education Funding Council for Wales (HEFCW)			1							**1**
Natural Resources Wales	2	5	1				1			**9**
Student Finance Wales		1	1		1					**3**
Welsh Language Commissoner			1							**1**
Total	2	6	4		1		1			**14**

Independent Care Providers

Independent Care Providers	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Marjorie Kirby (Warrendale Cottage Residential Home)			1							**1**
NHS Independent Care										
Glanbury Care Home				1						**1**
Nant y Gaer Hall Nursing Home								1		**1**
Self Funding Independent Care										
Craig Y Trwyn Care Home				1						**1**
Gofal Gwynedd Care Ltd			1							**1**
Hallmark Care Home Ltd							1			**1**
Hawthorn Court Care Home							1			**1**
Kinmel Lodge Residential Home			1							**1**
Springbank Nursing Home	1									**1**
Trewythen Hall Care Home									1	**1**
Lakeside House Nursing Home		1								**1**
Loving Care									1	**1**
The Oaklands Residential Home									1	**1**
Sevacare			1						1	**2**
Torestin Care Home Ltd (Brynderwen Care Home Ltd)			1							**1**
Ty Porth Care Home		1								**1**
TOTAL	1	2	5	2			2	1	4	**17**

Other

Other	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
National Assembly for Wales Commission	1									**1**
Body out of jurisdiction	4									**4**
TOTAL	5									**5**

Annex C

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

County/County Borough Councils

County/County Borough Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Blaenau Gwent	3							**3**
Bridgend	9							**9**
Cardiff	14		1				2	**17**
Carmarthenshire	3	3	1	1				**8**
Conwy	2							**2**
Denbighshire	5							**5**
Flintshire	1							**1**
Gwynedd	6							**6**
Isle of Anglesey	1	1						**2**
Monmouthshire	4		1	1				**6**
Neath Port Talbot	2							**2**
Newport	2							**2**
Pembrokeshire	5		1	2				**8**
Powys	13							**13**
Rhondda Cynon Taf	3		1					**4**
Swansea	11							**11**
Torfaen	5		1					**6**
Vale of Glamorgan	6					1		**7**
TOTAL	95	4	6	4		1	2	**112**

Community/ Town Councils

Community/Town Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Abergavenny Town			1					**1**
Abertillery & Llanhilleth Community	17							**17**
Aberystwyth Town	1						1	**2**
Amroth Community		1						**1**
Bangor City	1							**1**
Bargoed Town	1							**1**
Barry Town						1		**1**
Brackla Community	1						1	**2**
Bronwydd Community	1							**1**
Buckley Town	1							**1**
Builth Wells	1							**1**
Caldicot Town	2							**2**
Connah's Quay Town				1				**1**
Crickhowell Town	1							**1**
Devauden Community	1							**1**
Dinas Powys Community					2			**2**
Fishguard & Goodwick Town	1							**1**
Garw Valley Community	4	1					1	**6**
Glynneath Town	22							**22**
Gorseinon Town	2							**2**
Gwehelog Fawr Community	1							**1**
Holyhead Town	14							**14**

Community/ Town Councils (Continued)

Community/Town Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Llanddew Community	6							**6**
Llanedi Community		1						**1**
Llanelli Rural	2		1					**3**
Llanelli Town				1				**1**
Llanfynydd Community [Carmarthenshire]							1	**1**
Llanfynydd Community [Flintshire]				1				**1**
Llangattock Community	1							**1**
Llangefni Town	2							**2**
Llanover Community		1						**1**
Llansteffan & Llanybri Community				1				**1**
Llantilio Pertholey Community	3						7	**10**
Llantwit Fardre Community	1							**1**
Llanwrtyd Wells Town		2						**2**
Llywel Community	1							**1**
Magor with Undy Community						1		**1**
Manorbier Community	1		2		1			**4**
Merlins Bridge Community	1							**1**
Mumbles Community	5							**5**
Neyland Town							1	**1**
Northop Community	1							**1**

Community/ Town Councils (Continued)

Community/Town Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Penmaenmawr Town			1					**1**
Pontyclun Community	1							**1**
Porthcawl Town	1						1	**2**
Radyr and MorganstownCommunity	5							**5**
Saltney Town	1							**1**
Towyn & Kinmel Bay Town	2							**2**
Trefeglwys Community				1				**1**
Tywyn Town	6			1				**7**
Welsh St Donats Community	2							**2**
Welshpool Town	3							**3**
TOTAL	117	6	5	6	3	2	13	**152**

National Park Authorities

National Park Authority	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Brecon Beacons	1							**1**

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