Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

CONTRIBUTING TO EXCELLENCE

ANNUAL **REPORT** 2009/10

The Annual Report 2009/10

of

The Public Services Ombudsman for Wales

Laid before the National Assembly for Wales
under paragraph 14 of Schedule 1
of the Public Services Ombudsman (Wales) Act 2005

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

1. Introduction

"The past year has been demanding and constructive. At its heart lies the core work of my office in investigating complaints from members of the public about public services in Wales and the conduct of members of local authorities."

Peter Tyndall
Ombudsman

I am pleased to introduce this, my second, annual report since taking up my post as Ombudsman and the fourth annual report of the Public Services Ombudsman for Wales following the introduction of the office in 2006.

The past year has been demanding and constructive. At its heart lies the core work of my office in investigating complaints from members of the public about public services in Wales and the conduct of members of local authorities. Previous reports have talked about the relentless rise in complaints since the creation of the office. This year has seen a levelling off, although the workload of the office remains high due to the rise in health and member conduct complaints which are often more complex to investigate.

There has been a welcome reduction in complaints about maladministration by local authorities. In part, this may well be attributable to better complaint handling by authorities themselves, and my office has seen real efforts by many authorities to respond more effectively to complaints. It is also likely to reflect the continuing transfer of housing stock from local authorities to housing associations, a sector which has shown a small increase in complaints which is almost certainly entirely a consequence of its growth.

The number of complaints about health bodies rose by 5% during the year. These ranged from complaints about funding or delay in providing services, to complaints about clinical errors where individuals have sadly died as a consequence. There is a very considerable variation in the standard of complaint handling in the sector and I believe the recent consolidation into fewer bodies offers a real opportunity to raise standards. The proposed health redress measure has been a long time in gestation, and I look forward to its implementation. My caseload reveals a real need for proper, thorough management of complaints within the new Health Boards, with an emphasis on avoiding inappropriate defensiveness, a commitment to putting things right, learning the lessons from individual complaints and from complaint patterns all contributing to a renewed emphasis on getting things right to reduce the need for putting them right after the event. I intend working closely with those responsible for managing complaints in the health sector to ensure that the potential improvements are realised.

The other major increase has been in complaints about the conduct of local authority members, which have risen by 24%. In a year where public confidence in elected representatives has been a constant theme, I am concerned with this trend. Work on developing guidance on the Code of Conduct was undertaken during the year for publication in April 2010. I very much hope that councillors will take on board the advice and direction given and that complaints in this area will fall in the forthcoming year.

My work is concerned with investigating complaints for individuals, and helping to put them back where they would have been if they had not suffered an injustice because of maladministration or poor service, where this is possible. Sometimes injustice arises from one-off mistakes but, in other instances, it is indicative of deep-seated weaknesses in the services they have received which, if not addressed, are likely to be repeated.

The more serious cases where I found it necessary to publish public interest reports are summarised at Annex A. Many of these reveal underlying weaknesses in the services provided. In one case, the investigation revealed deep-seated flaws in a local authority's services for people with learning

disabilities which failed to protect a service user from assault. Another investigation found that a patient tragically died as a result of failures in a Health Trust's services for people with Ear Nose and Throat cancers. In these and other instances, my recommendations call for fundamental changes to the services concerned to ensure that other service users do not experience similar shortcomings in the future.

In order to ensure that these recommendations are effectively implemented, I have stepped up my working with regulators in the relevant sectors during the year. I am very pleased to say that key bodies such as the Care and Social Services Inspectorate for Wales and Health Inspectorate Wales are now taking a lead role in ensuring that compliance with my recommendations is secured, and bodies such as the Care Council for Wales are looking at any implications in respect of individual practitioners.

While considering cases about people with learning disabilities receiving day services, it has become obvious that the fact that these services are not regulated in the way that residential services and domiciliary care are, is inconsistent and potentially putting individuals at risk. The people using the services are often the same, and there is no reason to suppose that they are less at risk in a day setting than they would be in residential care or at home. The Welsh Assembly Government is considering this matter and I hope that it can be addressed.

This year was the first of our three year Strategic Plan which was developed to improve the service we offer and which took account of pressures on the service and reflected the views expressed by service users. Details of our Vision and Strategic Aims are at Annex D.

The plan envisaged a change to the way in which we engage with complainants. We have reconfigured the service to enable individuals to contact us by phone or email, rather than require them to complete a form. Our new Complaints Advice Team went live in January. We aim to give callers a clearer picture of how our service works and how we may be able to help them. If the complaint is not one we can deal with, because it falls outside our remit, e.g. complaints about the police, we will try to help them access the appropriate body. If they have not yet complained directly to the body which is the subject of their complaint, we'll help them to do so. If the complaint appears capable of being resolved quickly, we will contact the body concerned and ask them to try to resolve it, so that we will only investigate where it is necessary. We have also streamlined our work through a range of measures including enabling staff to conclude less complex cases by letter rather than requiring the production of lengthy investigation reports.

I am very pleased to see that early indications show that the changes are having the desired effect. Overall, we increased by 6% the number of cases closed during the year compared to 2008/09. As the changes were introduced in the last quarter I expect further improvement in 2010/11.

We have also been working on two new initiatives during the year. The first is the introduction of a new complaints signposting service for Wales to help those people who have a complaint about a public service but do not know who to complain to or how to go about it. It is hoped that this will be launched early in 2011. The second initiative has been the development of a common, streamlined complaints system for adoption by public service providers in Wales. I have chaired the Complaints Wales Group drawn from across the public sector which expects to put forward advice to the First Minister of the

Welsh Assembly Government in September 2010. A common process would offer many advantages, making it easier for people to complain, easier to manage complaints about joint services and easier to learn wider lessons about services and about complaints handling.

In closing, I would like to pay tribute to my staff. They are a committed, high skilful and very effective team. In a year which has seen major changes to the service, to nonetheless close more cases than has ever been achieved previously is a testament to their resilience and determination. They are motivated by a desire to ensure that users of public services have access to effective redress when things go wrong and that lessons are learned for the future. They play a key role in the development of excellent public services for the people of Wales and I am very grateful to them for the excellent results they achieve.

Peter Tyndall
Ombudsman

2. The Role of the Public Services Ombudsman for Wales

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

Complaints about public bodies in Wales

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

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

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

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

The Public Services Ombudsman (Wales) Act 2005 provides two ways for reporting formally on my investigations. Reports under section 16 of the Act are public interest reports and almost all are published. The body concerned is obliged to give publicity to such a report at its own expense. Where I do not consider the public interest requires a section 16 report (and provided the body concerned has agreed to implement any recommendation I may have made) I can issue my findings under section 21 of the Act. Depending on the nature and complexity of the investigation this will sometimes be in the format of a report, or it can take the form of a letter. There is no requirement on the body concerned to publicise section 21 reports or letters, although details of them can be found on my website. Summaries are currently available from my office on request, although it is my intention to begin publishing these in electronic form during 2010/11.

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

The Public Services Ombudsman (Wales) Act 2005 also gives me the power to do anything which is calculated to facilitate the settlement of a complaint, as well as or instead of investigating it. In the right circumstances, a 'quick fix' without an investigation can be of advantage to both the complainant and the body concerned. Since taking up my role as Ombudsman, I have been keen to see greater use made of this power and that we seek to identify as many cases as possible that may lend themselves to this kind of resolution. I am pleased that it has been possible to increase the number of cases settled in this way this year, and I hope that this will increase further now that the Complaints Advice Team is in place (see page 23 for further information)

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

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

Where I decide that a complaint should be investigated, there are four findings that I can arrive at:

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

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

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

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

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

3. Complaints of Maladministration and Service Failure

Caseload – overall position

For the first time since the PSOW office came into existence, the number of complaints about maladministration or service failure has fallen. As the figures in the table below indicate, the overall level of complaints about public bodies has decreased by 8% compared to the position for 2008/09.

	Total Number of Complaints
Cases carried over from 2007/08	445
Cases reopened in 2008/09	6*
New cases 2008/09	1,501
Total complaints 2008/09	**1,952**
Cases carried over from 2008/09	585
Cases reopened in 2009/10	26*
New cases 2009/10	1,381
Total complaints 2009/10	**1,992**
Cases to be carried forward to 2010/11	**563**

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

The office also dealt with 754 enquiries during 2009/10. Enquiries are contacts made by potential complainants asking about the service provided, which do not in the end result in a formal complaint being made to me. Last year 813 such enquiries were received, thus a fall of 7%.

I noted last year my concern about the impact the previous year on year increases in complaints was having on the number of cases being carried forward from one year to another. I am very pleased, therefore, that we have managed to begin to reverse the position this year, with 563 cases being carried forward to 2010/11 compared to the 585 cases brought forward into 2009/10.

Sectoral breakdown of complaints

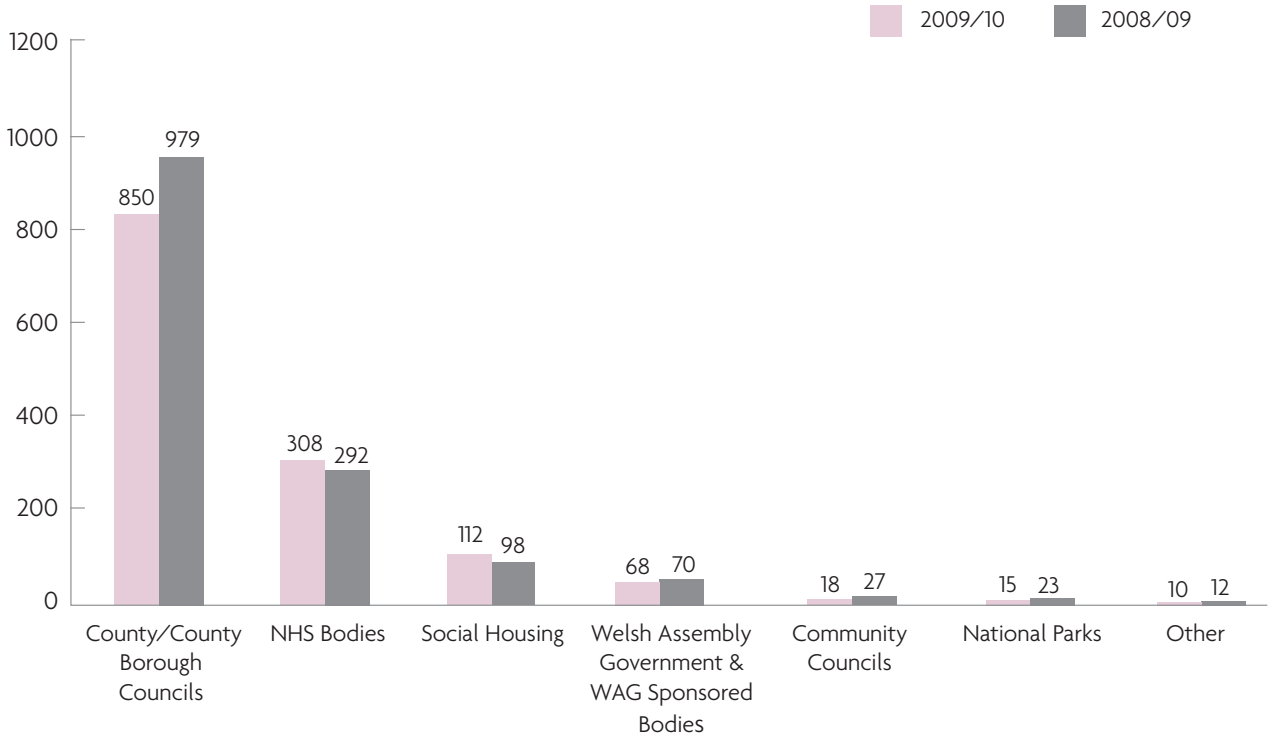
The pattern of previous years is that the vast majority of complaints received are in respect of county councils. As the chart below shows, this continues to be the case and is to be expected given they are direct providers of a wide range of services to the public. I referred above to the fall in the overall number of complaints received and it is noteworthy that that fall can be attributed to a considerable degree to the fact that the number of complaints about this sector of the public service in Wales fell to 850 complaints compared to the 979 received in 2008/09.

There has been a slight increase in the number of complaints received against registered social landlords (112 compared to 98 in 2008/09). I believe that it is likely that this is at least in part a consequence of housing stock transfers from a number of county/county borough councils to housing associations. It probably also contributes in small part to the decrease in the number of complaints received about county/county borough councils.

However, it is noticeable that the number of complaints in respect of NHS bodies continues to increase (308 compared to 292 in 2008/09). I will address the impact of this on my office elsewhere in this report.

The level of complaints against other sectors remains relatively low, which can largely be attributed to the fact that for those bodies such as community councils and the Welsh Assembly Government the extent of the services directly provided to the public is relatively small compared with county councils and NHS bodies.

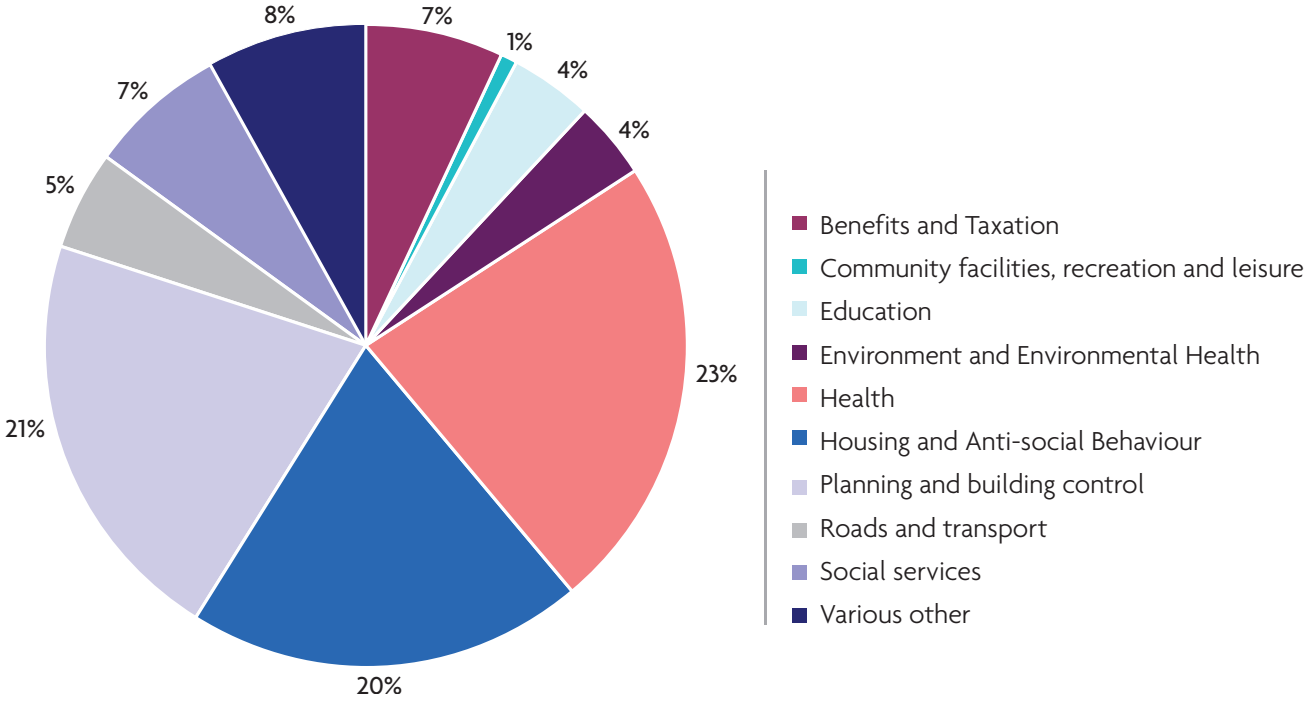
Complaints by public body sector



Complaints about Public Bodies by Subject

Until 2007/08, housing and planning complaints were the most numerous type of complaint received, with health generally making up around 15% of the caseload. However, last year health complaints accounted for 21% of the caseload. As the chart below demonstrates, this year this has increased again and now accounts for 23% of the complaints received. Planning is now in second position making up 21% of the caseload, with housing complaints close behind at 20%. I believe that there are two main reasons for the rise in health complaints. The first being that many complainants are now choosing to complain direct to me as Ombudsman rather than taking their complaint to the (optional) Independent Review Stage of the NHS complaints procedure. The second reason, is continuing high numbers of complaints about applications for continuing health care funding.

Complaints by Subject



Outcomes of Complaints Considered

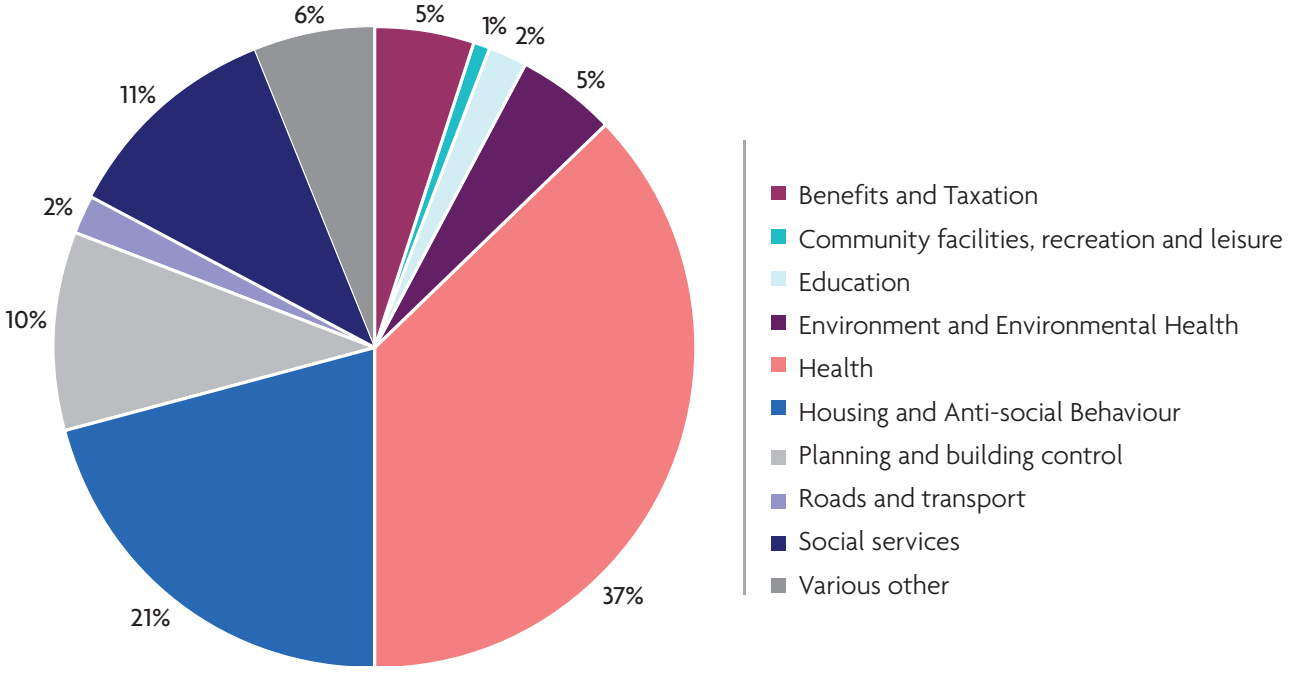
An overall summary of the outcomes of the cases closed during the past year, and a comparison with the position last year is given in the table below. I referred in Section 1 of this report to the fact that we introduced changes with a view to being better able to cope with the volume of casework being received by the office. I am very pleased, therefore, to be able to report that we achieved an increase in the number of cases closed over the past year compared to 2008/09. This was partly due to the increase in use of 'quick fixes' and also through closing less complex cases under Section 21 of the PSOW Act by letter rather than a formal report.

The number of complaints resolved by a 'quick fix' or upheld following investigation was higher (totalling 241 compared with 205 in 2008/09). Of those 241 cases, it is striking that health complaints accounted for 37% of these outcomes (see chart below).

(A breakdown by listed authority of the outcome of complaints investigated during 2009/10 is set out at Annex B.).

Complaint about a Public Body	2009/10	2008/09
Decision not to investigate	893	876
Complaint withdrawn	67	45
Complaint settled voluntarily (including "quick fix")	90	65
Investigation discontinued	187	241
Investigation: complaint not upheld	54	55
Investigation: complaint upheld in whole or in part	136	115
Investigation: complaint upheld in whole or in part – public interest report	15	25
Total Outcomes – Complaints	**1,442**	**1,422**

Proportion by subject of quick fix/upheld cases



Decision Times

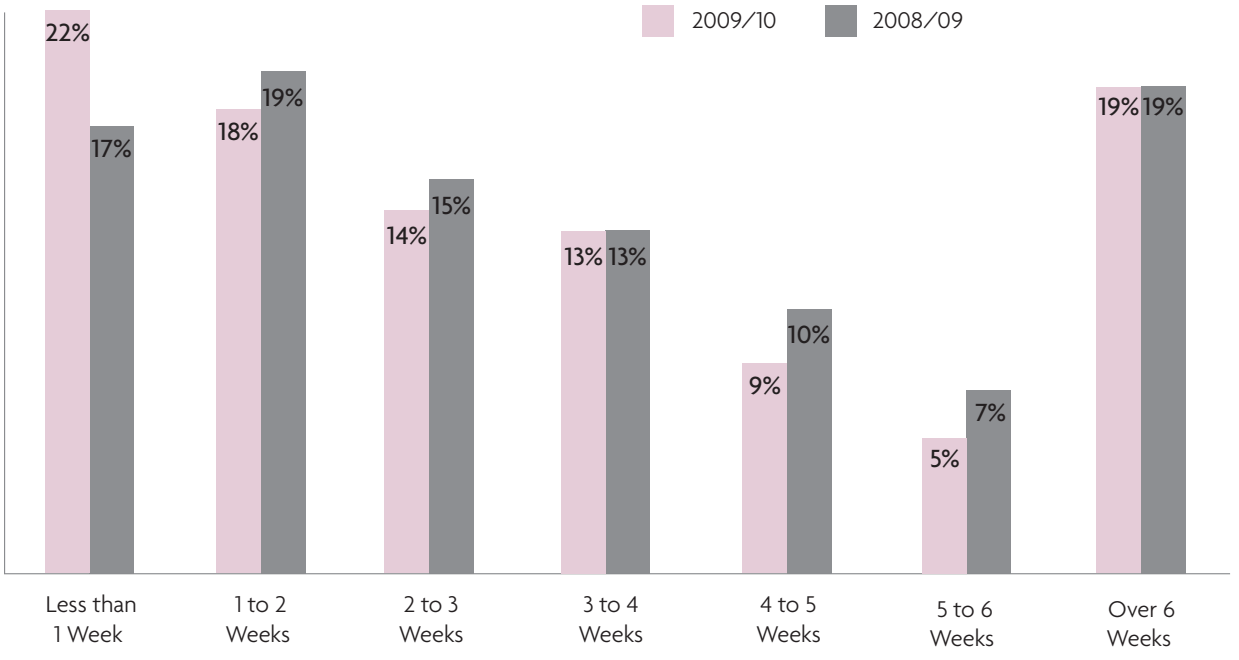
Overleaf are two charts which report on the two types of decision time targets we set ourselves.

We aim to tell complainants within 4 weeks whether we will take up their complaint. The situation in relation to this target has improved slightly in 2009/10 being achieved 67% of the time compared with 64% in 2008/09.

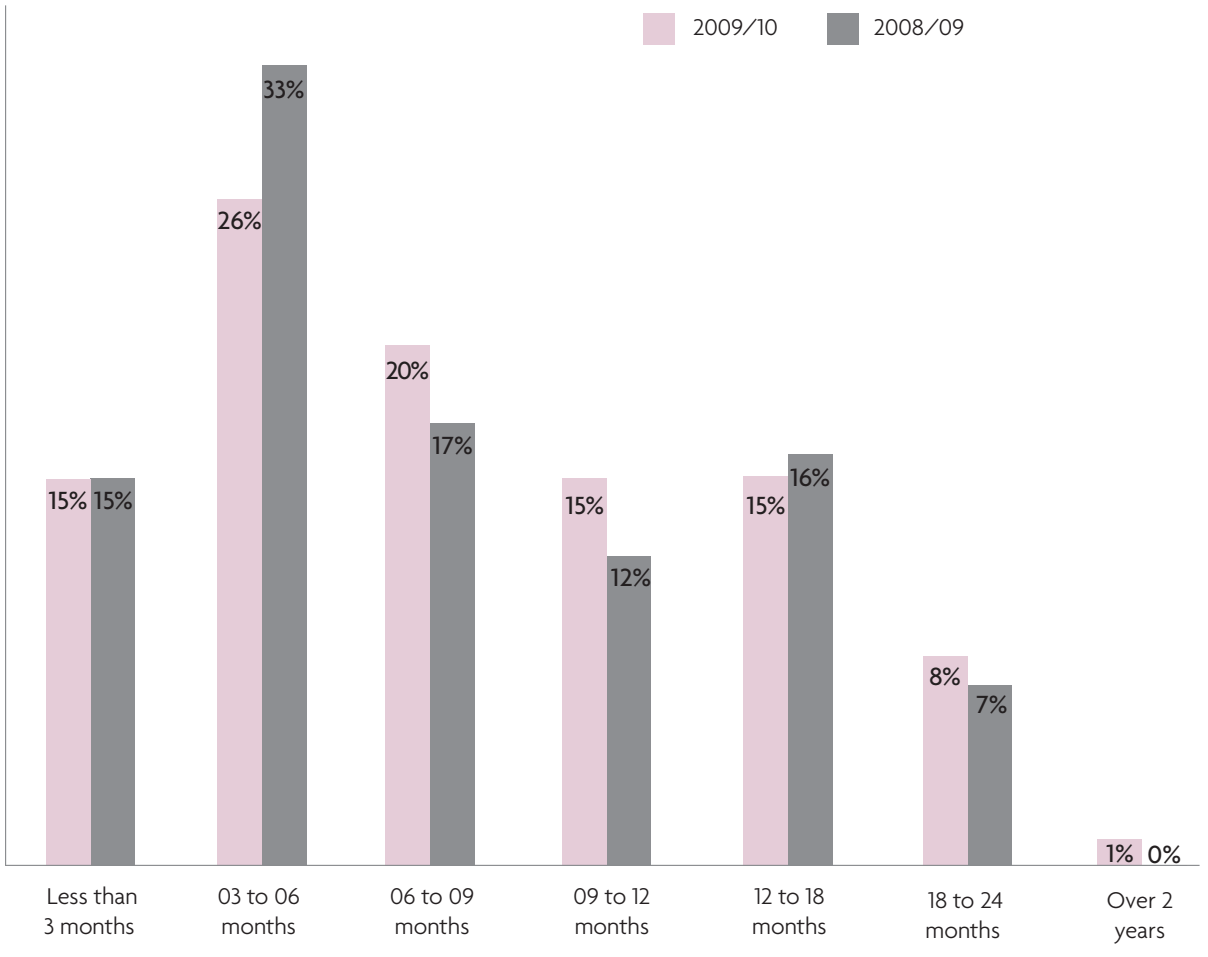
The second target we set ourselves is to conclude cases within 12 months from the point that a decision is made to take up a complaint (that is, to commence investigation of a complaint). This was achieved in respect of 76% of cases in 2009/10 compared to 77% in 2008/09.

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

Decision times for informing complainants if complaint will be taken up



Decision times for concluding investigations of public body complaint cases



It is disappointing that little progress has been made in relation to decision times. However, in terms of the investigation timescales, account still has to be taken of the impact of the unprecedented 29% increase in complaints received during the first half of 2008/09, which were still in the system in 2009/10.

However, I expect that this position will be improved upon in 2010/11, when the changes to our processes introduced in the final quarter of the past year will have had an opportunity to make their mark. However, I would add a word of caution in this respect. I have referred above to the continuing increase in health cases being received. These cases often involve consideration of very extensive records, and professional advice is normally required. In addition, many cases require large numbers of interviews to be conducted and considered. There is a balance to be struck which requires cases to be dealt with as quickly as possible, but not to the detriment of thoroughness and objectivity.

Joint Investigations

Under the PSOW Act, I am also able to co-operate with other Ombudsmen. During the year, I conducted one joint investigation, which was with the Parliamentary and Health Services Ombudsman in England. This investigation concerned a woman living in Wales who became acutely ill during a stay in England. Her case involved a Primary Care Trust in England, Health Commission Wales and an NHS Trust in Wales. The complaint was upheld (see Annex A for details).

4. Code of Conduct Complaints

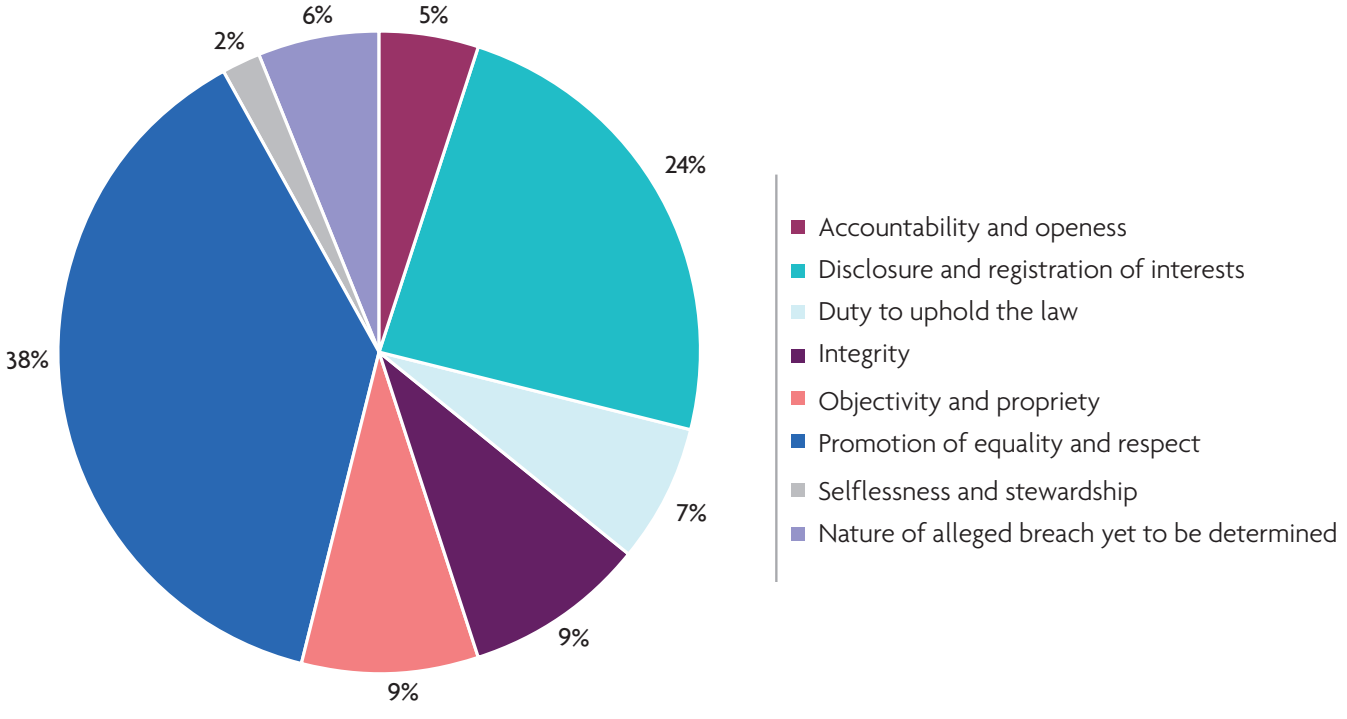
Complaints Received

The table below gives a breakdown of the code of conduct complaints received by type of authority. Last year I reported that there had been an increase in the number of complaints received. That upward trend has continued. In fact, there has been a substantial 24% increase (352 compared to 285). This has had an impact on the ability to deal with cases as quickly as we would wish. I address this issue later in this section.

	2009/10	2008/09
Community Council	163	132
County/County Borough Council	183	153
National Park	3	-
Police Authority	3	-
Total	**352**	**285**

Nature of Code of Conduct Complaints

Of the areas of the Code that members were alleged to have broken, the most common type relates 'equality and respect'. As the chart below shows, this accounted for 38% (this was 34% in 2008/09) of the complaints received. The next significant area relates to 'disclosure and registration of interests' which accounts for 24% of the complaints received.



Summary of Code of Conduct Complaint Outcomes

Of the Code of Conduct cases considered in 2009/10 it was decided that the large majority did not call for an investigation. However, the number of cases which I concluded should be referred to either an authority's standards committee or to the Adjudication Panel for Wales was considerably higher in the past year than in the previous year, that is: 26 compared to 8 in 2008/09. This is partly a consequence of the higher number of complaints, partly a reflection of the sadly increased number where conduct falls short of expectations and partly evidence of our commitment to actively continue to promote high standards in public life.

	2009/10	2008/09
Decision not to investigate complaint	214	184
Complaint withdrawn	16	17
Investigation discontinued	15	4
Investigation completed: No evidence of breach	6	3
Investigation completed: No action necessary	26	15
Investigation completed: Refer to Standards Committee	12	5
Investigation completed: Refer to Adjudication Panel	14	3
Total Outcomes – Code of Conduct complaints	**303**	**231**

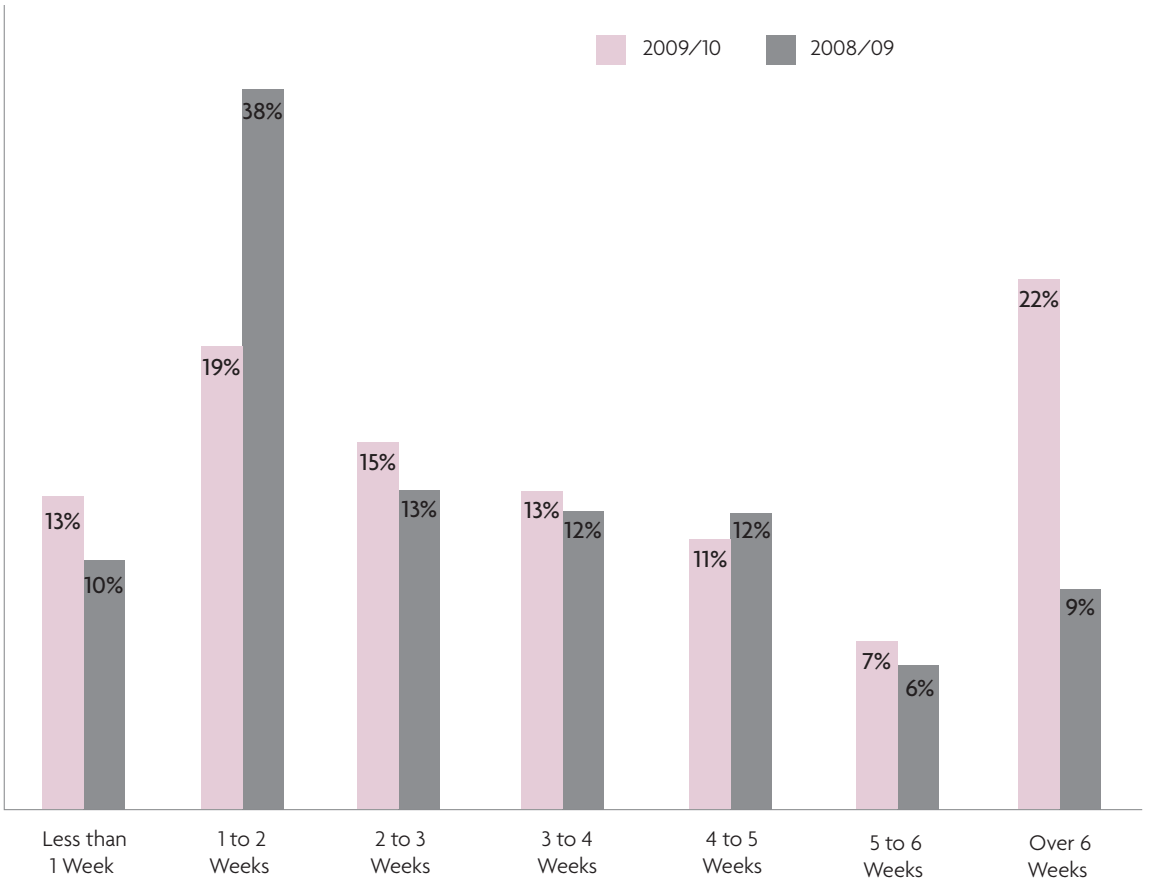
(A detailed breakdown of the outcome of Code of Conduct complaints investigated, by local authority, during 2009/10 is set out at Annex C.).

Decision Times

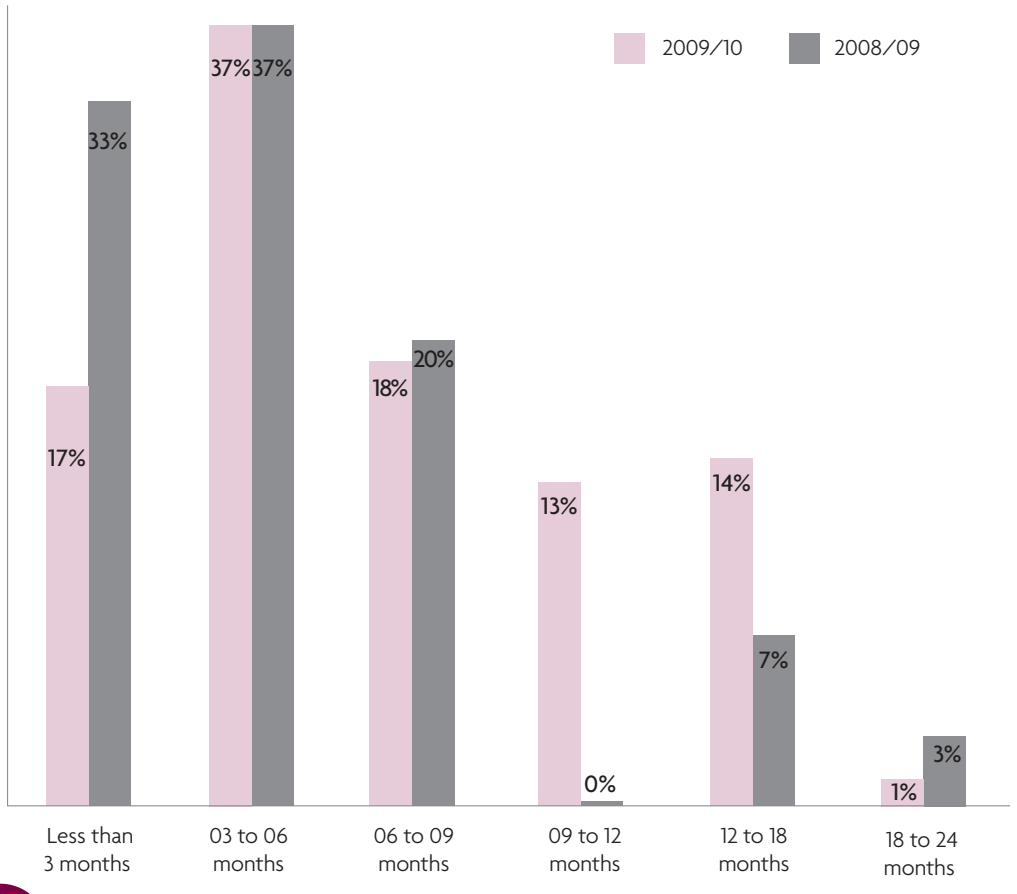
Overleaf are the decision times for code of conduct complaints. The time targets set for code of conduct complaints are similar to those for complaints about public bodies, i.e.

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

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



Decision times for concluding code of conduct complaint cases



Being the subject of a Code of Conduct complaint is a stressful experience for a councillor. This can be heightened by the media speculation that frequently surrounds such complaints. I am disappointed therefore that we have not been able to maintain the good performance of last year in terms of timescales. In particular, that 15% of investigations took over 12 months compared with 10% in 2008/09.

However, I am conscious of the fact that the team that considers Code of Conduct complaints has had to deal with the 24% increase in complaints of this type. In addition, amongst its casework has been a complex investigation concerning 32 members of one local authority which has had a disproportionate impact on the casework. I expect this case to be brought to a conclusion by May 2010.

As I mentioned last year, Code of Conduct investigations are increasingly being undertaken to criminal investigation standards. This is as the result of members who are the subject of an allegation increasingly engaging legal representation. Thus, my investigations in relation to Code of Conduct complaints have been changing in nature. The additional work that this involves for my office has had an impact on the length of time it takes to bring a case to a conclusion. Similarly, as more cases than in previous years have been referred to the Adjudication Panel and to standards committees more work has been necessary in preparing for and attending hearings. However, I am confident that the changes in process we have adopted will lead to improved performance in the year ahead.

Code of Conduct for Local Authority Members

In response to requests from local authority monitoring officers and others, I have developed guidance for local authority members on the Model Code of Conduct issued in 2008. This has been prepared following an initial consultation inviting local authorities to identify which aspects of the Code they would value guidance upon, and a subsequent consultation with the Association of Council Secretaries and Solicitors, One Voice Wales, the Welsh Assembly Government and the Adjudication Panel for Wales on the draft. The document has now been finalised and it is intended to publish this at the end of April 2010. We will hold a number of seminars on this guidance for chairs of standards committees, monitoring officers, and community council clerks during the forthcoming year.

5. Contributing to Excellence

The key focus of the work of the office is considering individual complaints and, in relation to cases about public bodies where injustice has been found, to secure appropriate redress for the people concerned. However, there is an important role for an Ombudsman beyond this as expressed in the vision set out in our Strategic Plan:

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

This can be done in many ways and I will refer to some below.

Public interest reports

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

There were 15 public interest reports issued in 2009/10. Summaries of each of these are at Annex A and their full text is available on my website at www.ombudsman-wales.org.uk.

Section 21 Reports

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

However, although the issues may not be of public interest when considered in isolation, I believe that there may still be lessons that can be learnt if they form part of a pattern of similar outcomes. I have, therefore, been concerned that such learning opportunities are not lost. In response to this, preparations have been in hand this year to introduce a Case Digest, containing summaries of all investigations closed under Section 21 of the Public Services Ombudsman Wales Act. We will begin issuing the Digest to public bodies early in 2010/11 in the form of a quarterly bulletin.

Complaints Advice Team and Signposting Service

As previously mentioned in this report, the Complaints Advice Team (CAT) became operational in January 2010. The team members consist of experienced investigators and complaint support officers. They deal with our frontline responses to the public and are encouraged to look for effective, swift and innovative ways to resolve the concerns of those who contact us. The early indications are positive. We are already achieving more 'quick fixes' and even those people we cannot help appreciate receiving a decision promptly and by phone.

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

- We secured an urgent review appointment for someone where their biopsy sample was lost by the Trust pending our investigation being started (the patient prior to our intervention was unable to be reassured whether their skin growth was cancerous or not).
- A complainant said he was getting little sense from various agencies in response to his complaint that asbestos material had been dumped near his home. We contacted the Council and located the appropriate officer. Arrangements were made for the material to be collected later that day.
- A complainant said they had made many requests to the Council regarding a faulty boiler, but it kept breaking down. We asked the Council to promptly send an engineer to thoroughly examine the boiler. The engineer subsequently condemned the boiler and recommended the installation of a whole new central heating system. This was approved by the Council.
- A complainant said he had waited for nine months for various repairs to be carried out at his property. We asked the Housing Association to send a contractor to assess the repairs, promptly. The repairs were agreed and contractors began the repairs within two weeks of the complaint to this office.
- We picked up at a very early stage a case which caused concern about the actions of a pharmacist and immediately referred this to his professional body.

As can be seen the benefit of working this way is that people's complaints are resolved at a much earlier stage than had we taken the matter to formal investigation. Further, public service providers have the opportunity to repair their reputation in the eyes of service users by responding promptly to the recommendations I make in relation to 'quick fixes'.

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

The development of the new service was contingent on securing the necessary additional public finance required to establish the new service. Given that I have to remain independent from government bodies, it would not be appropriate for me to act as an agent for the Welsh Assembly Government in this regard. It was, therefore, agreed that I would deliver this service in my own right, subject to the funding necessary to provide it being approved by the National Assembly for Wales. I, therefore, sought funding directly from the National Assembly as part of the normal budget round. That funding was approved in my budget submission for 2010/11 and, accordingly, an implementation project is now underway. We are aiming to launch the service early in 2011.

The signposting service will be seen by the public as a separate service from the ombudsman service. It will have its own identity and branding. My aim is that it should not only advise people on which public service provider they should complain to, but that it should also capture the crux of their complaint and (with the complainant's consent) send the details on to the relevant public body on their behalf. However, it is not intended that the signposting service be a portal for all public service complaints. Complainants will, as now, be able to complain directly to the relevant service provider. The service is primarily for people who need help to identify to whom they should be making their complaint and how best to do so. In sending on the details of the grievance to the relevant public body, I will then look to it to accept this as a complaint made by complainant themselves and not to ask them to complete another form. In this way, those who have a grievance should have smooth access to the public body's complaints process.

Complaints Wales

I made brief mention in my report last year that the Welsh Assembly Government was considering developing a common complaints handling process for public service providers in Wales. I had been invited to put forward a paper setting out the potential and benefit of such an arrangement. Subsequently, the Welsh Assembly Government decided that it wished to proceed in developing a proposal and to this end I was then asked to Chair a working group. (I was pleased to accept given that this work is consistent with my powers under the Public Services Ombudsman (Wales) Act 2005 to issue guidance in relation to good complaints handling.). The membership of the Complaints Wales Group was made up of people in a position to represent and consult with the various public service sectors in Wales as the work of the group progressed (for example, Welsh Local Government Association, Community Housing Cymru).

At the end of 2009/10 a near final draft document had been developed. The document is in two parts. The first element being a model policy, which is customer facing (i.e. the text addresses the potential complainant) and includes a proposed standard complaint form; the second part consists of design criteria for complaints handling procedures. The key element of the proposals is that there should only be two stages to the complaints process: an informal stage where people can complain to frontline staff and a second formal stage, where there is proportionate consideration/investigation of the complaint. Should the complainant remain unhappy at the end of this second stage, then the independent avenue open to them is to refer their complaint to me as Ombudsman or other appropriate independent complaint handler (e.g. currently the Welsh Language Board in respect of complaints about failure to comply with Welsh Language Schemes). The aim will be to consult with public service providers and interested parties at the end May/early June with advice being submitted to the First Minister in September 2010.

I believe that a common, streamlined, complaints procedure is a prize worth pursuing. It will make the process of complaining easier for members of the public, particularly so for those whose grievance spans services provided by more than one public body. I know of no other example where all public bodies within a nation adopt the same complaints procedure – and this could be a world first for Wales.

NHS Redress in Wales

At the time of writing, the consultation period on the Welsh Assembly Government's proposals for the handling of claims, complaints and incidents has just closed. The proposals included the proposition that the Independent Review stage of the NHS complaints procedure be abolished. Should this come to fruition then the new model will be consistent with the current proposals for the Complaints Wales model.

6. Accessibility and External Communication

Accessibility

It is important to me that my service should be open to everyone who uses public services in Wales. One of the core values in the strategic plan is accessibility, where I want my service to be 'open to everyone from all of our communities and work to ensure that people who face challenges in access are not excluded. We will be courteous, respectful and approachable, and communicate with complainants in the way they tell us they prefer'.

One of the improvements we have made in response to this is to revise our key public brochure on how to complain to the Ombudsman. The new booklet 'Want to complain about a public body? You and the Ombudsman' is more user friendly in its approach, compared to its predecessor.

The complaint form is no longer an integral part of the booklet. In response to user consultation we want to encourage people to telephone us first prior to putting their complaint in writing. The aim here is two-fold: first to give the complainant a better understanding of our processes and what the Ombudsman can and cannot achieve for them should their complaint be upheld; secondly, so that we can prevent premature complaints coming to us (i.e. those complaints where the public body has not had the opportunity to address the complainant's concerns). It is also at this point that we can establish with complainants their preferred method of communication with us and whether there are circumstances that mean we need to engage with them in any particular ways.

As well as being produced in Welsh and English, the booklet has also been made available in eight other languages (Arabic, Bengali, Cantonese, French, Hindi, Polish, Somali and Urdu). Translations into other languages are available on request. In addition, arrangements were made at the end of the year for it to be produced on CD and tape.

To supplement the information booklet, we have also produced 18 subject specific factsheets across a whole range of topics including hospital treatment, protection of vulnerable adults, homelessness, anti-social behaviour and planning applications, which provide more tailored advice in relation to the type of complaint in question.

External Communication

Outreach – General Events

We also met regularly with monitoring officers and the Welsh Local Government Association. We work closely with relevant officials of the Welsh Assembly Government and regulators to ensure that they are aware of the implications of our casework in the areas for which they are responsible. We spoke to meetings of representatives from housing associations, with representatives of Community Health Councils and Community Councils and with the Association of Directors of Social Services in Wales.

I addressed the All Wales Local Government Standards Conference in Cardiff and the annual conferences of the Administrative Justice and Tribunals Council and its Welsh Committee, of which I am an ex officio member.

Our outreach programme is necessarily restricted as most of our resource is focused on investigating complaints and we have also had to focus on delivering major changes to our organisation and processes during the year. We have nonetheless continued our targeted programme of interaction with advocacy bodies.

We had a stand at the National Eisteddfod for Wales in Bala. This gave us an opportunity to explain our role to members of the public who called in to see us and also to engage with representatives of voluntary organisations who were present on the Eisteddfod field. We will have a stand at the Eisteddfod to be held in Ebbw Vale in 2010.

We have taken opportunities to meet on an individual basis with relevant organisations. These have ranged from having a presence at a seminar arranged by Displaced People in Action aimed at refugees and asylum seekers to meetings with bodies working with people with learning disabilities and older people. We also participated in a seminar on Administrative Justice in Wales organised by the Public Law Project.

We have continued to build our links with the Children's and Older People's Commissioners for Wales.

Outreach – bodies in jurisdiction

During the first two weeks of February we held a series of seminars around Wales, for contact and complaints officers of the bodies in jurisdiction. There was a dual purpose to the seminars. The first was to explain and discuss our new approach to complaint handling and the impact of this on complaints officers. The second was to discuss and informally consult on the work of the Complaint Wales group, particularly to assess reaction to the overall principle of a common, streamlined complaints procedure. It was pleasing to see that overall there was a good deal of support amongst the complaints officers for what was being proposed. These seminars were also an opportunity for complaints officers to raise general issues in relation to the work of my office.

The outreach work of the office was extensively enhanced by media coverage of reports, which draws my service to the attention of members of the public who may wish to complain about public services in Wales.

7. Governance

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

Audit Committee

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

Although a 'corporation sole', an Audit Committee had previously been established and charged with advising the Ombudsman in discharging his duties as Accounting Officer. The current Chair of the Committee is Mr Laurie Pavelin, CBE, FCA.

The Audit Committee reviewed its terms of reference and membership at the end of the 2008/09. The Committee's remit was extended to include consideration of issues such as the Strategic Plan and it was also decided that the level of independent membership should be increased. An open recruitment procedure was undertaken. Following an interview process of strong candidates, Professor Margaret Griffiths was appointed as an independent Member. She took up appointment in June 2009.

RSM Bentley Jennison act as my internal auditors and their programme of work is guided and overseen by the Audit Committee. As a result in a change of the committee cycle, the Audit Committee met five times during 2009/10. I am pleased that no substantive matters of concern were raised during this time.

Complainant satisfaction survey

Research via complainant satisfaction surveys has been an important means to understand complainants' views of the service we provide. Opinion Research Services (ORS) has been providing this service for us over recent years, via quantitative research inviting all complainants to complete and return survey forms and on a sample basis a limited qualitative telephone follow up.

However, particularly in view of our new ways of working, we decided during the year that we should adopt a new approach. We will now conduct a satisfaction survey of all those complainants who contact our Complaints Advice Team to ensure that our new arrangements are working effectively. We will be seeking to understand at this stage whether, for example, people contacting this service believe that staff have sufficient knowledge to be able to answer their questions, whether staff are helpful and sensitive to callers' circumstances and whether complainants' expectations of the service are being met.

The second element of our survey work will then be undertaken by ORS who, on a sample basis, will undertake in depth interviews (usually by phone, but face to face if this is more appropriate in the circumstances of the complainant) with those people whose complaints have been investigated. The aim is to achieve an even better understanding from the complainant's perspective of what we do well

and what we can perhaps improve upon. Development work and a pilot project took place at the end of the year. We will introduce the new approach once we have made the necessary changes to our internal arrangements. This is likely to be in June 2010.

Human Resources

I would not be able to fulfil my function as Ombudsman if it was not for my staff. I was fortunate in inheriting a committed and expert workforce which has evolved to meet the challenges we are facing. It is vital that provision is made to enable continual development and work has commenced on reviewing our existing staff appraisal and training processes and provision which have been closely linked to the objectives in the strategic plan. We have been undertaking work in preparation for our aim of being recognised as Investors in People which will be given greater priority as our new arrangements bed down.

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

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

Learning from other Ombudsmen

I consider the work of the British and Irish Ombudsman Association (BIOA) to be important. Ombudsman schemes need to be objective and maintain an appropriate distance from the bodies in jurisdiction. Consequently, it is essential that we learn from the best practice of other similar ombudsman schemes. BIOA offers the opportunity to share best practice, learn from one another and discuss common issues of concern.

During the year I was honoured to join the BIOA Executive Committee and subsequently Deputy Chairperson. Members of my staff represent me on a number of the BIOA Interest Groups.

We have also been assisting with preparations for the Annual Meeting of the British and Irish Ombudsman Association, which will be held in Cardiff on 14 May 2010. I am very pleased that Lord Dafydd Elis-Thomas, Presiding Officer of the National Assembly for Wales, and Dame Gillian Morgan, Permanent Secretary at the Welsh Assembly Government have agreed to join the speakers. This will be the first time that the event will be hosted here and I look forward to welcoming colleague Ombudsmen to Wales. The day prior to this, we will be hosting our own workshops for members of BIOA, where we will be holding sessions on: Administrative Law; Redress and Managing Complainants' Expectations.

The year 2009 was an important one in the world of the Ombudsman as it marked the 200th anniversary of the establishment of the first post of Ombudsman. This first post was created in Sweden and in recognition of this the International Ombudsman Institute held its four-yearly conference in Stockholm. It was a privilege to be present and often a humbling experience when hearing accounts of the work of Ombudsmen in countries such as Rwanda and the Ukraine.

I also greatly value the opportunity to participate in the UK and Ireland Public Services Ombudsman meetings.

Complaints about the PSOW Service

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

The 'Complaints about us' procedure can be used if someone is unhappy with:

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

They can also use the complaints procedure to complain about other things. For example, to complain about undue delay in responding to correspondence; or that a member of staff has been rude or unhelpful; or that we have not done what we said we would.

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

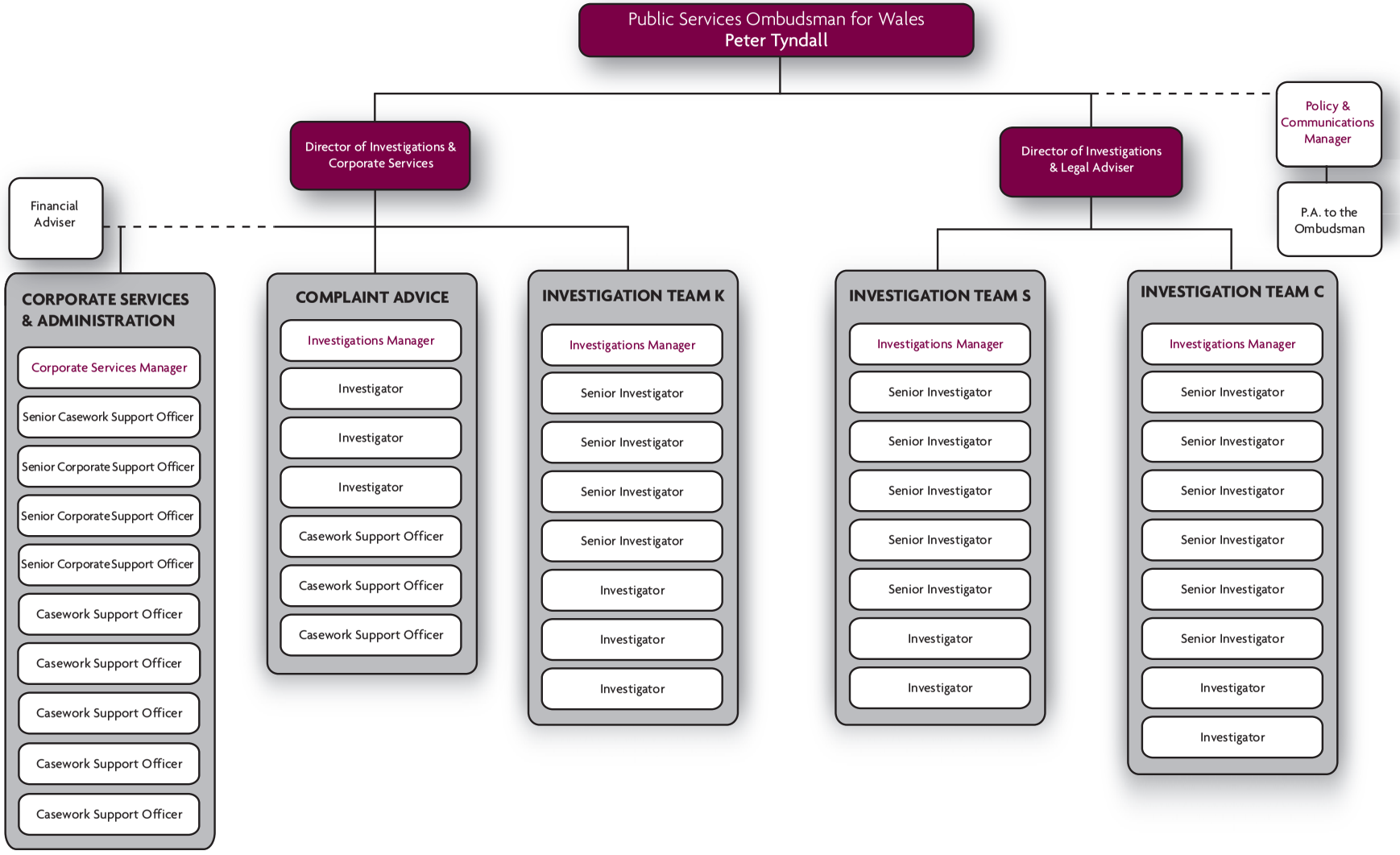
The information below on complaints received is for the past year only. It is not possible to provide a like-for-like comparison with complaints made in 2008/09 due to the fact that the 'complaints about us' procedure was revised in 2009/10.

Details of the 'complaints about us' received	2009/10
Not upheld	8
Referred to Ombudsman (appeal against case decision)	10
Upheld in whole or in part	5
Still open at 31 March	0
Total received	**23**

Details of the five cases upheld in whole or in part are as follows:

Subject of complaint about us	Outcome	Action taken
Time taken to assess complaint about public body.	Partially upheld.	Letter of apology sent.
Complaint expressing concern about interview processes.	Partially upheld.	Letter of apology sent. Additional guidance issued to staff together with additional training.
Complainant not contacted back as requested.	Partially upheld.	Letter of apology sent.
Complaint that contact information provided had not been updated.	Partially Upheld.	Whilst unable to trace notification, letter of apology for inconvenience caused was sent.
Complaint concerning delay in investigation with no regular updates received from investigator.	Upheld.	Letter of apology sent.

Organisational Chart



Annex A

Public Body Complaints
Public Interest Reports: Case Summaries

Health: Cwm Taf NHS Trust
(Public Interest Report 200801882 issued February 2010)

Mrs D complained that there were excessive delays in diagnosing her husband's cancer, despite the fact that he had reported symptoms for a number of years. She was also concerned that her husband was not offered adequate pain relief. Sadly, Mr D passed away during the course of my investigation.

I found that initial investigations into Mr D's ear pain carried out at Prince Charles Hospital in Merthyr Tydfil in 2006 were reasonable; relevant tests and examinations were done, and nothing abnormal was found. It was therefore entirely reasonable that Mr D was referred back to the care of his GP.

Mr D's GP referred him back to Prince Charles Hospital in April 2007 as he had now developed a hoarse voice in addition to the ear pain. Mr D was seen in the Ear, Nose and Throat Department by a Staff Grade Doctor in May 2007 and was referred for a CT scan of relevant areas. The CT scan did not take place until November 2007; and it was a further three weeks before the scan was reported on. The scan showed signs suggestive of cancer. I found that given the symptoms reported by Mr D in May 2007, he should have been referred for an urgent CT scan. The referral form for the CT scan had not been entered on the Trust's computer system and had subsequently been destroyed. It was therefore impossible to say whether the Staff Grade Doctor had failed to mark the referral as "urgent", or whether there was a clerical error in the radiology department which led to the referral being incorrectly categorised as "routine" on the computer system. The effect of this was that Mr D had to wait six months for a scan which should have been done within 2 – 3 weeks.

Once the CT scan had been reported in December 2007, Mr D underwent a number of diagnostic tests at Prince Charles Hospital. It was not until April 2008 that his diagnosis was confirmed (albeit not all the delays in this period were within the Trust's control). I found that the management of the investigations between December 2007 and April 2008 was somewhat chaotic. Had a lymph node biopsy been done at the outset, it is likely that the diagnosis would have been arrived at sooner and saved Mr D the trouble of having to undergo most of the other investigations, some of which he found uncomfortable.

I was unable to say whether or not Mr D's prognosis would have been different had the cancer been diagnosed sooner; however, I upheld the complaint that there had been unreasonable delay. Mr D should have received an urgent scan, but this did not happen. Once the scan had been done, the subsequent investigations should have been undertaken in a more coherent and targeted way. The consequence for Mr D was that he had to wait 11 months for the diagnosis following his ENT appointment in May 2007; during which time he was in pain. I partially upheld the complaint about inadequate pain relief as it is very difficult to adequately manage a person's pain until the cause is known.

I was pleased to note that the then Trust had already accepted some failings and apologised to Mr and Mrs D. It had also made significant improvements to the radiology department at Prince Charles Hospital. I noted that even patients referred for routine scans are now seen within six weeks, and the majority within four weeks, of referral. I made two recommendations aimed at improving the radiology service further, and also recommended that Cwm Taf Health Board (as successor to the previous Cwm Taf NHS Trust) should formally apologise to Mrs D for the delays her husband experienced.

Health: Carmarthenshire Local Health Board (Public Interest Report 200800779 issued December 2009)

Mr A complained that Carmarthenshire Local Health Board ("the LHB") did not make its decisions clear and failed to commission the necessary care, for his son, Mr B, after the latter was deemed eligible for full NHS continuing care.

Mr B suffered a major brain injury in 2006. He left hospital in 2007. A multidisciplinary team had concluded that Mr B was eligible for continuing care and required stated amounts of physiotherapy, occupational therapy and speech and language therapy.

Some of the package of care was arranged with core NHS services and the LHB commissioned some further input from NHS providers. However, a large part of the package was not provided to Mr B. He did not receive sufficient physiotherapy or occupational therapy and had no speech and language therapy. After a number of representations were made to the LHB, Mr A eventually funded much of the shortfall privately.

Mr A submitted a complaint about the LHB. This was reviewed by the Independent Review Panel. The review found that the LHB had mishandled its response to Mr B's case in the light of the multidisciplinary team's assessment of his needs and eligibility for continuing care. The LHB accepted the review's findings.

Mr A made the complaint to me because Mr B had not received the level of service that he required according to the multidisciplinary team. My investigation involved collecting large amounts of documentary evidence, interviewing Mr A, LHB officers and providers of care to Mr B. I also took expert advice from one of my professional advisers.

I found that the LHB's written decision making was very confusing and that Mr A and NHS providers of care were left unclear about Mr B's status in terms of continuing care. However, my central conclusion was that the LHB failed to commission sufficient services for Mr B to meet his assessed needs and did so, without adequate justification. As such, Mr B lost out on some of the care he needed and Mr A spent large sums of money when he should not have needed so to do.

I upheld the complaint and made a number of recommendations. These included financial redress to Mr A and Mr B and a new multidisciplinary assessment of Mr B's needs. The successor body to the LHB, Hywel Dda LHB, has agreed to implement all the recommendations.

Health: Anglesey Local Health Board (Public Interest Report 200800349 issued September 2009)

Mr K works for a transitional rehabilitation unit ("the Unit") in Northern England. He complained on behalf of a patient of the Unit, Mr Z, against Anglesey Local Health Board ("the LHB"). Mr Z was eligible for fully funded NHS continuing care at the time that the predecessor NHS body to the LHB, a Health Authority, placed Mr Z in the Unit in 1999.

In 2003 the Health Authority stopped funding Mr Z's placement. The incoming LHB has never made any payments to the Unit for Mr Z's placement. The Isle of Anglesey County Council took responsibility for the payments from 2003 and has paid since that date. However, the Council's contribution has not kept pace with rising costs. The Unit said that it was out of pocket by many thousands of pounds.

The LHB did not take responsibility for the payments or investigate Mr Z's health when the Unit approached it in 2007. Moreover, the LHB could find no conclusive evidence that the Health Authority had found Mr Z ineligible for continuing care in 2003 or before. Nor could it show that a formal decision had ever been taken or imparted to Mr Z or his representatives.

I concluded that the Health Authority should not have stopped paying for Mr Z's placement. If it had not done so, the LHB would have inherited the liability for funding Mr Z's care at the Unit. This did not happen and as a result, Mr Z's tenure has been put at considerable risk.

I upheld the complaint and recommended, among other things, that the LHB repay the Unit £110,000 towards the shortfall in funding that had accrued.

Health: Cardiff & Vale NHS Trust, Health Commission Wales and Plymouth Teaching Primary Care Trust (Published jointly by the Public Services Ombudsman for Wales and the Health Service Ombudsman for England) (Public Interest Report 200701674, 200701085 and 200800010 issued July 2009)

Mrs S's adult daughter, Miss S, lived in South Wales. However, while staying with a friend in the south west of England, she became depressed and required treatment for anorexia nervosa. She came under the care of Plymouth Teaching Primary Care Trust (the PCT), initially as an out-patient and then, from October 2006, as an in-patient. In October 2006 the PCT approached a consultant psychiatrist in Miss S's home area (the Welsh Consultant) employed by Cardiff and Vale NHS Trust (the Trust) to ask him to take over her care. He declined. Miss S's condition deteriorated further and she was referred to the local specialist NHS eating disorders unit (the EDU). The referral was accepted, subject to funding, and an application was made to Health Commission Wales (HCW) for this. HCW refused to fund the admission, principally on the grounds that Miss S had never been assessed by the NHS in Wales, and because no follow-up plan had been put in place for when she was discharged. Mrs S then elected to have Miss S admitted to a private eating disorders centre, where she and her daughter, funded the care themselves.

Mrs S complained to me on behalf of Miss S that the NHS should have funded Miss S's care. She complained that the family had been forced to take action as Miss S's condition was serious and deteriorating, and because it appeared that the question of which NHS body was responsible for funding was unlikely to be resolved quickly. She commented that it was out of the question for Miss S to have travelled to Wales for assessment, given her poor condition. Mrs S said that because of all this, she and her daughter were forced to use their life savings to pay for private treatment.

I found maladministration or service failure in the following respects:

- HCW adopted an excessively inflexible approach to the request to fund Miss S's in-patient care. In particular, HCW:
  - failed to take into consideration all relevant factors (including that Miss S was not at home when she became ill and her only sources of social support were outside Wales);
  - failed to take into consideration the valid opinion of an English Consultant when it was reasonable to do so;
  - insisted that a detailed discharge or follow-up plan was in place when it was not reasonable in the particular circumstances to do so; and
  - failed to communicate adequately its conditions for funding.
- The Trust unreasonably refused the request to take over Miss S's care in October 2006.
- The PCT failed to provide short-term funding for Miss S's treatment and thereby placed her at clinical risk.

I concluded that the maladministration and service failure we identified had caused Miss S and her mother injustice and hardship: they were clearly caused significant distress by the failure to resolve the funding issues appropriately and expeditiously as Miss S's condition deteriorated rapidly, and they each spent considerable sums of money paying privately for treatment which the NHS should have funded.

I recommended that HCW should reimburse Mrs S and Miss S the money they had paid (approximately £31,000) for Miss S's care, together with the interest they would have received had it remained in their accounts. I also recommended that all three bodies pay Miss S and Mrs S £250 each to recognise the distress they had been caused. I also made a number of procedural recommendations which were addressed to HCW.

This investigation identified a number of general concerns about the adequacy of provision for patients with eating disorders in the Cardiff and Vale area, and in Wales in general. I therefore recommended that the Trust carry out an urgent review of the provision for eating disorder patients in its area, in conjunction with the relevant local health boards and that the Welsh Assembly Government gave consideration to carrying out a Wales-wide review of the adequacy of provision for the treatment of eating disorders in Wales, both from an out-patient and an in-patient perspective.

HCW, the Trust, the PCT and the Welsh Assembly Government accepted my recommendations.

Health: Cwm Taf NHS Trust (Public Interest Report 200801427 issued July 2009)

Mr M complained about cardiac treatment he received at Prince Charles Hospital in 2006/2007.

Mr M made a number of criticisms of the Former North Glamorgan NHS Trust that was responsible for the hospital at that time. His complaint was handled by the successor Trust – Cwm Taf NHS Trust. The Cwm Taf NHS Trust came into existence in April 2008. Mr M said that the Former Trust mishandled his care after he had been admitted to hospital after a suspected heart attack. He accused the Former Trust of:

- unjustifiably delaying a follow up appointment to see a cardiac specialist
- failing to refer him for an angiogram which was clearly and vitally indicated by test results
- cancelling an appointment with a specialist that had been arranged to review his case
- employing a Locum Consultant for many years without him gaining the relevant qualifications to be a permanent consultant.

Mr M said that these failures meant that he had to wait many months longer for cardiac surgery than should have been the case. He said that this left him in danger of a heart attack and caused him great stress whilst he was awaiting an appropriate medical response. As a result of the poor standard of care that he received, Mr M claimed that it has left him with a fear of NHS treatment.

The investigation involved viewing medical records and complaint documents, interviewing Mr M and the relevant Consultant, speaking to a key Trust Director and seeking the advice of one of my professional advisers.

I strongly upheld Mr M's complaint in all its aspects. I found that it was a serious clinical error by the Trust not to refer Mr M for an angiogram when it had the opportunity in early 2007. Instead, it referred him for a test that was not appropriate for someone with his condition. This mistake occurred within and was partly prompted by, a lack of capacity for angiography in the area of the Former Trust at that time.

I made a number of recommendations. These included redress to Mr M, revisiting a review of patients who were referred for the same test as Mr M and carrying out a review of its cardiology arrangements. I was pleased that the Trust agreed to implement the recommendations.

Health: Pontypridd and Rhondda NHS Trust (now the Cwm Taf NHS Trust) (Public Interest Report 200700780 issued May 2009)

Mr H was referred to North Glamorgan NHS Trust in September 2006 by his GP because of a suspicious lump in his neck. He was seen by a Consultant Surgeon and subsequently by members of his team. Investigations were then undertaken over the next three months and although clinical staff suspected the presence of a malignant tumour on the base of his tongue, a formal diagnosis of this was not obtained until December 2006. Following this diagnosis, a multidisciplinary meeting took place in January 2007 where it was decided that the best way to treat the tumour would be by operating to surgically remove one half of Mr H's tongue (a procedure known as a hemiglossectomy). The operation was scheduled to take place at the Royal Glamorgan Hospital, which was managed by the former Pontypridd and Rhondda NHS Trust, on 22 January 2007 although there was no MRI scan taken beforehand to establish the extent of the tumour's spread. In theatre Mr H was anaesthetised and a tracheostomy tube was inserted into his trachea (windpipe). A tracheostomy tube is a tube which is inserted into the tracheal space to enable the patient to breathe through it if the normal airway is obstructed. Whilst still under anaesthetic the surgeons examined Mr H's tumour with an endoscope and concluded that the tumour had spread to a greater extent than they had originally envisaged. As a result they decided that the hemiglossectomy should not go ahead. The tracheostomy tube was left in place however.

Surgeons subsequently explained to Mr H and his family that the remaining treatment options involved the surgical removal of the whole of his tongue and his voice-box or a combination of radiotherapy and chemotherapy. Following discussions with staff Mr H elected not to undergo further surgery and arrangements were made for him to be treated at a specialist cancer centre (the Centre). Whilst awaiting transfer to the Centre Mr H's tube was changed by a surgeon. However during this procedure the replacement tube was misplaced outside the trachea within the tissue of the neck. A CT scan taken of Mr H's neck and chest shortly after the changing of the tracheostomy tube showed that the tube was misplaced although the reporting radiologist failed to draw attention to this misplacement. This misplacement of the tube was not identified by other staff at the Royal Glamorgan Hospital either and five days later Mr H was transferred to the Centre for chemotherapy. The day following his admission Mr H experienced acute bleeding from his tracheostomy tube. Staff at the Centre arranged for Mr H's immediate return to the Royal Glamorgan Hospital. Upon his return surgical staff also identified significant bleeding from the tracheostomy tube and Mr H was taken back to theatre to re-fashion the tracheostomy. The surgeon who refashioned the tracheostomy identified that the original tracheostomy tube had been located in a false tract and packed the wound and stitched up the wound. Mr H then returned to the ward the following day with the intention to recommence radiotherapy. Four days later Mr H experienced a catastrophic bleed from his tracheostomy site and died despite attempts by staff to resuscitate him. The post mortem report indicated that the cause of death was bleeding from an artery located at the base of the false tract.

My investigation concluded that the initial investigations into Mr H's condition were both slow and inadequate and that the nature of the tumour should have been identified at an earlier stage. I considered that if this had happened potentially there would have been a more favourable outcome

for Mr H. I also found that the surgery which was originally proposed was undertaken without sufficient information and that the procedure to insert the tracheostomy tube would have been unnecessary. I also found that whilst tracheostomy tubes can be misplaced when they are changed, it was not reasonable for this not to have been identified subsequently. I also found that the staff at the Royal Glamorgan Hospital had failed to take reasonable steps to investigate the reason for the acute bleeding Mr H experienced whilst at the Cancer Centre. I was also critical of the training provided to nursing staff on tracheostomy care and considered that the nursing care provided to Mr H in relation to his tracheostomy fell below a standard one could reasonably expect. I was also critical of a lack of appropriate protocols and documentation available on the ward in relation to tracheostomy care. I found that overall the care provided to Mr H had not been reasonable and that in fact the actions of Trust staff had directly resulted in Mr H's premature death. I upheld the complaint and drew attention to the fact that my Professional Assessors questioned whether it is appropriate for the Trust to deliver such an ENT service to patients unless significant changes are implemented. I made a number of recommendations which proposed changes to medical and nursing practices, training and operational procedures which the Trust should undertake if it was to continue to provide such ENT services in future. I also recommended that the Chief Executive and Chair of Cwm Taf NHS Trust* apologise in person to Mr and Mrs T for the failings identified in the report.

* [Note - on 1 April 2008 Cwm Taf NHS Trust took over the responsibilities and liabilities of both the former North Glamorgan and Pontypridd and Rhondda NHS Trust.]

Housing: Cardiff County Council (Public Interest Report 200702358 issued August 2009)

Miss Brown was a Council tenant living in a high rise block. She and her partner Mr Davies complained that she had been subject to anti-social behaviour including amplified music and threatening behaviour from a neighbour, also a Council tenant, for a period of six years. They said that they had complained to the Council repeatedly and had completed nuisance diaries as requested to assist the Council with addressing their complaints. They said that the Council had not communicated with them adequately nor did the different sections that were involved in their complaint appear to be working together. They had also made complaints through their MP and councillor but the problems continued. They said that the neighbour would have been on an introductory tenancy when he moved in and they could not understand why he had not been evicted early on in his occupation or subsequently after the complaints became more serious in nature and when he received a criminal conviction.

By the time my investigation was completed the perpetrator of the nuisance had been transferred by the Council in October 2008, for reasons unconnected with the complaints against him, however he remained in close proximity to the complainants and they said that they continued to live in fear.

My predecessor had issued a public report on Cardiff County Council in January 2007 in which he upheld complaints brought on behalf of three residents by Julie Morgan MP. They complained that they had suffered unaddressed anti social behaviour from a perpetrator for periods extending into years. He

found that the Council had failed to consider the full range of legal remedies available to deal with the behaviour and his report made various recommendations for improving the Council's response to anti social behaviour including improvements to internal communications and training for staff. The Council accepted the recommendations and implemented an action plan that was completed in March 2007.

Having concluded the investigation into Miss Brown's complaint, I was concerned that further failings in the Council's response to anti social behaviour had been identified, including the fact that it does not act appropriately in relation to terminating unsatisfactory introductory tenancies and that its procedures and actions do not take appropriate regard of human rights legislation. I also noted that long after the period for compliance on the last report, the Council had continued to fail in its responsibilities to the complainants and in particular had failed to consider the full range of legal remedies available to it to protect its tenants and bring the nuisance to an end.

In my report I recommended that the Council should transfer Miss Brown to suitable alternative accommodation, apologise for the failings and pay her £7,500 in recognition of the difficulties she had experienced. I also recommended that it should revise its procedures for dealing with anti social behaviour to take account of human rights and homelessness considerations and should provide further training to its staff in dealing with anti social behaviour sanctions including demotion of secure tenancies and termination of introductory tenancies. I also recommended that it should take steps to further improve internal communication.

I am pleased to say that the Council accepted my recommendations and is making significant improvements to its services to address the systemic failings identified.

Planning: Brecon Beacons National Park & Powys County Council (Public Interest Report - Case 200801193 & 200801194 issued March 2010)

Mr O, a property developer, complained that in July 2008 Powys County Council moved a family of Gypsies onto land adjacent to his own within the Brecon Beacons National Park and developed it without planning consent from the National Park Authority and without a development licence from the Welsh Assembly Government. He said that the unauthorised development had had a detrimental effect on his company's efforts to market its own development. He was concerned that enforcement action was not taken by the Authority and that there was a delay until April 2009 before a retrospective planning application made by the Council, which led to temporary consent for the site, was determined by the Authority. He also felt that information provided by the Authority's planning officers about the prospects of another permanent site had unfairly influenced the planning committee's decision to approve the temporary site for the family's use in the meantime.

The Council said it had urgently needed to move the family from a lorry park site in Brecon to the land available to it adjacent to Mr O's property while it sought to identify and develop a more suitable permanent site for them. Whilst I recognised the need to move the family from the lorry park site I upheld the complaint as I considered that sufficient information was available to the Council for it to have prepared a planning application for the temporary site in advance of the move. As

it was, a retrospective application was made but it was not considered and approved until eight months later because of staffing shortages at the Authority. That delay was unacceptable and I considered that it would have caused uncertainty for Mr O and his company who were keen to develop and market its own site. Both bodies agreed to pay £250 each to Mr O to reflect those difficulties.

In the same period the Council had identified a suitable permanent site for the family which required planning consent before it could be developed. I was satisfied that this information was properly made available to the Authority's planning committee when it considered the application for the temporary site. I did not uphold the complaint that the committee had been unfairly influenced into thinking that the proposed site would definitely be available to the family. I later learnt that consent to develop the proposed site had been refused. I therefore urged the Council to promptly consider alternative measures and suitable sites for the family to avoid ongoing long-term use of the temporary site.

Social Services: Powys County Council (Public Interest Report 200702004 issued May 2009)

The complainant (who was handling her mother's financial affairs) complained on behalf of her mother that she was not advised that income bonds were not taken into account as capital in an assessment of financial resources for the purpose of residential accommodation. In 2004 the complainant's mother had capital which was considerably in excess of the upper limit above which a client is normally liable to pay the full cost of residential accommodation. However, her capital was primarily in the form of income bonds. The care manager undertaking the assessment did not ask the nature of the capital, and did not advise the complainant that there were any forms of capital which were disregarded. As a result the financial assessment forms were not completed, and the complainant's mother funded her own residential care for a period of some 2 years 9 months. In July 2007 the complainant indicated to the care manager for the first time that her mother's capital was in the form of income bonds; the care manager carried out a financial assessment which resulted in the Council accepting responsibility for the cost of the residential accommodation in September 2007. If the financial assessment forms had been completed correctly at the outset the Council would have contributed to the funding of the residential accommodation. The Council refused the complainant's request to back-date the funding for the placement.

I found that the failure by the Council to advise the complainant of the way in which capital is treated for the purpose of the financial assessment amounted to maladministration. I recommended that the Council should (i) apologise to the complainant (ii) carry out a retrospective assessment of Mrs C's means for the years in question, and that, having done so, it should calculate the amount it should have contributed to her placements and (iii) pay to Mrs C's estate the difference between this amount and the sum which the Council had contributed to the placement between September 2007 and March 2008. I also recommended that the Council should review the information it provides to clients in connection with financial assessments to enable clients to make an informed decision on whether to disclose details of their financial affairs.

Subsequent to the issue of the report (Case no 200702004 – Powys County Council) the following accompanying note was produced

In May of this year I issued a report on the above investigation. I found that the Council had failed in 2004 to explain to the complainant that certain types of capital may be disregarded for the purposes of a financial assessment for assistance in meeting the costs of residential care. I concluded that this omission amounted to maladministration on the part of the Council. As a result the complainant's mother (Mrs C) declined a financial assessment and paid for her residential care herself for a period of some three years. The complainant approached the Council again in 2007 because her mother's savings were about to fall below the threshold for assistance with funding. The Council carried out an assessment of Mrs C's means and accepted that she was entitled to have her care costs met by the Council.

Mrs C's capital had been mostly in the form of income bonds and the complainant was told by the Council in 2007 that they should have been disregarded as "capital". This had formed the basis of the Council's decision to meet Mrs C's care costs. However the Council refused a request from the complainant to backdate her mother's entitlement to assistance to 2004. This is what led to her complaint to me.

There was no suggestion made by the Council during the course of the investigation that it had misinterpreted the regulations and that income bonds should have been taken into account as capital. Furthermore the Council accepted the recommendations in my report including a recommendation to carry out a retrospective financial assessment of Mrs C's means and having done so, to calculate the amount it should have contributed to the placement had it agreed to backdate her entitlement and to pay to Mrs C's estate the difference between this amount and the sum which the Council had paid towards the placement.

Shortly after the final report was issued the Council informed me that it had made an error in disregarding the bonds during the 2007 assessment because they were not "investment" bonds and that being so Mrs C was not in fact entitled to have her care costs met until her savings (including the income bonds) had dropped below the prescribed threshold. This meant that Mrs C had wrongly received assistance towards her care costs before she was legally entitled to it.

I sought independent advice on the status of income bonds and on the basis of the advice he received, he accepted that this was correct.

The Council agreed not to recover the contribution it had made in error towards Mrs C's residential home costs. It also agreed to pay her daughter, the complainant, the sum of £500 in recognition of the incorrect information she had been given and for the stress this had caused. I considered that this was a reasonable response in the circumstances.

The developments set out above reinforced my view that the other recommendations in his report remain valid namely:

"35. The Council should also review the information which it provides to clients in connection with financial assessments. It should provide sufficient information about the process to allow the client to make an informed decision as to whether disclosing full details of their financial affairs may be in their best interests. I believe that it is unreasonable to assume that the client is in a position to obtain sufficient information from elsewhere. The information should be provided, either by means of an indication on the financial assessment form, an oral explanation by the finance officer when completing, or attempting to complete, the form, or, preferably, by an information leaflet being provided to the client. The information provided should, at the

very least, indicate that there are certain kinds of capital which would not necessarily take the client over the threshold above which they would be charged the full cost of services provided.

36. Finally, all care managers and finance officers should be fully trained in their obligation to provide to clients such information as I have identified above."

Social Services: Carmarthenshire County Council (Public Interest Report 200600720 and 200700758 issued September 2009)

Sally, a vulnerable woman, was physically abused at a day centre run by the Council in June 2005 ("the first abuse"). The complainant, "Ms West" reported the abuse in October 2005. I found that the Council's Social Services Department failed to deal properly under its own procedures with the allegation of abuse. Sally was again physically abused in July 2006 ("the second abuse"). This was investigated by the Police. Ms West again drew attention to the first abuse and to the Council's failure to investigate it properly. The Department took some action to investigate the first abuse but I found that its investigation was flawed.

Ms West complained to the Council about its failure to take appropriate action. I found that the Council failed to deal properly with her complaint.

I identified many instances of serious maladministration and service failure in the way in which the Council dealt with the abuse of Sally and with Ms West's complaints. I found evidence of pervasive management failure in the Learning Disabilities service at the time, characterised by lack of leadership and accountability and by a failure to comply with even minimum standards of good practice. This had left both service users and staff alike at risk. I found that the maladministration and service failure had caused considerable distress to Ms West precisely because she had followed good practice in reporting the abuse. I found that injustice had also been caused to users of the service who had been left at risk by the failure of the Social Services Department, and to staff who were obliged to operate in such an environment. I noted that since the events recorded in this report, the Council had taken action to address many of the shortcomings I identified.

I subsequently agreed with the Council that the Care and Social Services Inspectorate for Wales (CSSIW) will monitor the changes to the service to ensure that my recommendations are complied with. In addition, I drew possible professional issues to the attention of the Care Council for Wales.

Social Services - Pembrokeshire County Council (Public Interest Report Case 200800024 issued March 2010)

Mr W complained that the Council delayed in responding to concerns about the welfare of his son A, when in his mother's care. Mr W said that A was at risk of harm and suffered from neglect which should have been addressed earlier. Mr W was also unhappy that the Council did not keep him informed, although he had parental responsibility.

I found that although social workers were aware of A's mother's family history, early assessments did not address the need to ensure that A's mother acknowledged the risks and kept her children safe. A referral that A was being left alone with a second close family member, convicted of child abuse, was not properly investigated. When enquiries were made about this several months later it prompted a Child Protection Conference.

Overall the investigation confirmed serious shortcomings. The Council was tardy in initiating child protection procedures despite referrals from the emergency services in December 2005. This pointed to an 18 month delay before A was registered as a child at risk and measures should have been taken sooner to safeguard A and to promote his welfare. Referrals had also been made from A's school - by both the school nurse and the Head Teacher - but there was no written record of the Council's response. I could only conclude that these concerns were not taken into account. Also the Council's failure to respond to the Head Teacher 's request for a child protection conference, made on behalf of a number of concerned professionals, did not accord with the spirit of multi agency working.

I found that A had suffered as a result of the Council's delay in taking action. The Council agreed to implement my recommendations included payments of £5,000 to A and £500 to Mr W for identified shortcomings in complaint handling and for his time and trouble in submitting the complaint. The Council also agreed to provide audits of child protection referrals. I was reassured that the Council had taken steps to address the shortcomings identified. Once again, I will be working with CSSIW to ensure that my recommendations are effectively implemented.

Annex B

Public Body Complaints

Statistical Breakdown of Outcomes by Public Body Complaints Investigated

COUNTY/COUNTY BOROUGH COUNCILS

County/County Borough Council	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Blaenau Gwent	1	10	10		2		1	1	2	**27**
Bridgend	11	4	11	5	1			1	1	**34**
Caerphilly	5	10	13	10	5		3	2	3	**51**
Cardiff	5	23	20	12	4	1	9	1	2	**77**
Carmarthenshire	4	23	17	11	3	2	6	5	1	**72**
Conwy	5	6	4	1	2		1	1	2	**22**
Ceredigion	3	5	8	4	3		3	1	3	**30**
Denbighshire	4	6	14	3	1		2	1	6	**37**
Flintshire	4	10	6	6			5	1	2	**34**
Gwynedd	11	10	14	12	5		2	1		**55**
Isle of Anglesey	6	10	9	2	4		1	1	5	**38**
Merthyr Tydfil	3	6	6	2			3			**20**
Monmouthshire	2	3	11	1	2		1			**20**
Neath Port Talbot	7	15	14	5	1		3	1	3	**49**
Newport	6	9	11	4	3					**33**
Pembrokeshire	2	8	14	4	3	1	2	2	3	**39**
Powys	7	18	17	4	3	2	3		4	**58**
Rhondda Cynon Taf	10	14	15	4	4		5		1	**53**
Swansea	5	7	8	12	2		2	2	2	**40**
The Vale of Glamorgan	7	8	12	4	3		3	2	2	**41**
Torfaen	5	6	13	3	1				1	**29**
Wrexham	2	8	4	7	5		1	1	1	**29**
TOTAL	**115**	**219**	**251**	**116**	**57**	**6**	**56**	**24**	**44**	**888**

OTHER LOCAL AUTHORITY

Other Local Authority	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
National Park Authorities										
Brecon Beacons National Park Authority	2	1	1	2	1	1		1		**9**
Pembrokeshire Coast National Park Authority	1	1	2							**4**
Snowdonia National Park		2	2				1			**5**
Police Authorities										
Gwent Police Authority			1							**1**
Schools Appeals/ Admissions Panels										
Admissions Appeal Panel- Bishop Hedley R.C. School							1			**1**
Admissions Appeal Panel - Parkland Primary School								1		**1**
Admissions Appeal Panel - Rhydypenau Primary School			1							**1**
Governors Admissions Panel- Bishop Hedley Roman Catholic High School							1			**1**
Newton Primary School Appeals Panel			1							**1**
TOTAL	**3**	**4**	**8**	**2**	**1**	**1**	**3**	**2**		**24**

COMMUNITY COUNCILS

Community Council	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Argoed		1								**1**
Blaenhonddan	1									**1**
Brecon				1						**1**
Clydach			1							**1**
Corris			1							**1**
Kidwelly							1			**1**
Langstone								1		**1**
Llanidloes					1					**1**
Llantrisant			1							**1**
Llantwit Major			1							**1**
Minera		1								**1**
Monmouth			1							**1**
Neyland									1	**1**
Onllwyn		1								**1**
Pembroke Dock		1								**1**
Pontyclun			1							**1**
Pontypool		1								**1**
Porthcawl			1							**1**
Rhosllannerchrugog							1			**1**
Taffs Well			1							**1**
Talley				1						**1**
Tintern									2	**2**
TOTAL	**1**	**5**	**8**	**2**	**1**		**2**	**1**	**3**	**23**

REGISTERED SOCIAL LANDLORDS

Registered Social Landlord	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Bro Myrddin Housing Association							1			**1**
Bron Afon Community Housing Ltd	1	3	4	2	1				2	**13**
Cadwyn Housing Association Ltd									1	**1**
Cardiff Community Housing Association Ltd		1	1	1	1					**4**
Care and Repair Rhondda Cynon Taf Ltd	1									**1**
Cartrefi Conwy		1								**1**
Ceredigion Care & Repair		1								**1**
Charter Housing Association (1973) Ltd		2	3		1					**6**
Clwyd Alyn Housing Association Ltd		1	1		1		1			**4**
Coastal Housing Group Ltd	1	1		1	2					**5**
Cymdeithas Tai Cantref		2		1	1					**4**
Cymdeithas Tai Clwyd Cyf			1							**1**
Cymdeithas Tai Eryri				2			1			**3**
Family Housing Association (Wales) Ltd		2	3					1		**6**
First Choice Housing Association Ltd								1		**1**
Grwp Gwalia Cyf Ltd		2			1			1		**4**
Gwalia (Rest Bay Co-Ownership Equity Sharing) Housing Association								1		**1**
Hafod Care Association		1		1						**2**
Hafod Housing Association Ltd		1	1	1						**3**
Linc-Cymru Housing Association		1					1			**2**
Melin Homes Ltd		1		1	1		1			**4**
Merthyr Tydfil Housing Association Ltd				1	1					**2**
Merthyr Valleys Homes		2	1	1						**4**
Mid Wales Housing Association Ltd				1						**1**
Monmouthshire Housing Association		2								**2**
Newport City Homes	1	3		1	1					**6**

REGISTERED SOCIAL LANDLORDS (CONTINUED)

Registered Social Landlord	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Newydd Housing Association (1974) Ltd		2	2	1						**5**
North Wales Housing			1				1			**2**
Pembrokeshire Housing Association Ltd			1							**1**
RCT Homes Ltd	1	3		1			1			**6**
Rhondda Housing Association Ltd					1					**1**
Seren Group Ltd			1							**1**
Taff Housing Association				2					1	**3**
United Welsh Housing Association		2	1	3					1	**7**
Valleys to Coast Housing Ltd	1		1	1	1					**4**
Wales and West Housing Association Ltd	1	3	3	3					2	**12**
TOTAL	**7**	**37**	**25**	**25**	**13**		**7**	**4**	**7**	**125**

NHS TRUSTS AND LOCAL HEALTH BOARDS

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

Local Health Boards (pre October 2009)	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Anglesey						1	1			**2**
Bridgend			1					1		**2**
Caerphilly				1			1			**2**
Cardiff	1		3		2					**6**
Carmarthenshire		1	1			1	1			**4**
Denbighshire	1									**1**
Flintshire				1						**1**
Gwynedd		1					4			**5**
Monmouthshire				1			1			**2**
Neath Port Talbot							1			**1**
Newport				1						**1**
Pembrokeshire			1					1		**2**
Powys	1		1	5			2			**9**
Rhondda Cynon Taff		1	1							**2**
Swansea		1		1						**2**
TOTAL	**3**	**4**	**8**	**10**	**2**	**2**	**11**	**2**		**42**

NHS TRUSTS

NHS Trusts (pre October 2009)	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abertawe Bro Morgannwg University		11	2	3	3		3			**22**
Bro Morgannwg							1			**1**
Cardiff & Vale	1	4	3	8		1	11	3	2	**33**
Carmarthenshire							3			**3**
Conwy & Denbighshire							1	1		**2**
Cwm Taf	1	3	1	1		2	3	2	1	**14**
Gwent Healthcare	1	6	3	3			11	4		**28**
Hywel Dda	1	3	2	1			3	1		**11**
North East Wales							1			**1**
North Wales		3	2	3	1		2		1	**12**
North West Wales	1	2	2	2				1	2	**10**
Pembrokeshire & Derwen								1		**1**
Plymouth Teaching*						1				**1**
Pontypridd & Rhondda						1				**1**
Swansea							1			**1**
TOTAL	**5**	**32**	**15**	**21**	**4**	**5**	**40**	**13**	**6**	**141**

*(see page 17 - Joint Investigations)

LOCAL HEALTH BOARDS

Local Health Boards (1 October and thereafter)	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abertawe Bro Morgannwg University LHB	1	13			3		1		1	**19**
Aneurin Bevan LHB	1	8	1				2	1		**13**
Betsi Cadwaladr University LHB	1	3	2							**6**
Cardiff and Vale University LHB	1	6	1						1	**9**
Cwm Taf Local Health Board		1	1							**2**
Hywel Dda Local Health Board		3	3	1	2					**9**
Powys Teaching LHB		2	2							**4**
TOTAL	**4**	**36**	**10**	**1**	**5**		**3**	**1**	**2**	**62**

The following bodies continue with the title 'NHS Trust' and no distinction has been made in relation to complaints received pre and post 1 October 2009

NHS Trusts	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Velindre NHS Trust				1	1			1		**3**
Welsh Ambulance Services NHS Trust			1	3	2					**6**
TOTAL			**1**	**4**	**3**			**1**		**9**

TOTAL ALL LHB/NHS TRUST COMPLAINTS	**12**	**72**	**34**	**36**	**14**	**7**	**54**	**17**	**8**	**254**

OTHER HEALTH BODIES

Other Health Bodies	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
GPs	3	13	9	2	1		6	4	3	**41**
Dentist		2	1	2			2	1		**8**
Board of Community Health Councils in Wales							1			**1**
TOTAL	**3**	**15**	**10**	**4**	**1**		**9**	**5**	**3**	**50**

INDEPENDENT HEALTH PROVIDER

Independent Health Provider	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
British Pregnancy Advisory Service							1			**1**
Spire Cardiff Hospital							1			**1**
TOTAL							**2**			**2**

WELSH ASSEMBLY GOVERNMENT & WELSH ASSEMBLY GOVERNMENT SPONSORED BODIES

Welsh Assembly Government & ASGPB	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Assembly Sponsored Public Body										
Arts Council of Wales							1			**1**
Care Council for Wales			1							**1**
Countryside Council for Wales			1							**1**
CSSIW					1					**1**
Environment Agency	2		5		1					**8**
The Forestry Commissioners (for matters relating to Wales)			1							**1**
Welsh Assembly Government										
CAFCASS Cymru	3	4							1	**8**
Health Commission Wales			2					1		**3**
Healthcare Inspectorate Wales									1	**1**
Independent Review Secretariat			4	1			1			**6**
National Assembly for Wales Commission			1							**1**
Planning Inspectorate	1	1	4							**6**
Welsh Assembly Government	6	5	14	1	1		1			**28**
Welsh Assembly Government (Health Commission Wales)						1				**1**
TOTAL	**12**	**10**	**33**	**2**	**3**	**1**	**3**	**1**	**2**	**67**

OTHER BODIES

Other Bodies	Out of Jurisdiction	Premature	Investigation not merited	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Body not in jurisdiction	4									**4**
ESTYN			1							**1**
Valuation Tribunal Service for Wales	1		1							**2**
West Wales Valuation Tribunal	1	1								**2**
Total	**6**	**1**	**2**							**9**

Annex C

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

COUNTY/COUNTY BOROUGH COUNCILS

County/County Borough Council	Decision Not to Investigate	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Blaenau Gwent	2	1						**3**
Bridgend	7							**7**
Caerphilly	3							**3**
Cardiff	9			1		1	4	**15**
Carmarthenshire	2			1			1	**4**
Conwy	8				1			**9**
Ceredigion	2					3		**5**
Flintshire	4					1		**5**
Gwynedd	1							**1**
Isle of Anglesey	11	9	1			3	2	**26**
Merthyr Tydfil	5						1	**6**
Monmouthshire	2			1				**3**
Neath Port Talbot	2							**2**
Pembrokeshire	1			1				**2**
Powys	6		1	1			1	**9**
Rhondda Cynon Taf	3	1				1		**5**
Swansea	9	4	2		3	2		**20**
The Vale of Glamorgan	1							**1**
Torfaen	21			10	2			**33**
Wrexham	1		1					**2**
TOTAL	**100**	**15**	**5**	**15**	**6**	**11**	**9**	**161**

COMMUNITY/TOWN COUNCILS

Community/Town Council	Decision Not to investigate	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Barry Town	2						1	**3**
Beguildy				3				**3**
Blaenavon	1							**1**
Blaenhonddan	2							**2**
Borth	8		1					**9**
Brymbo	2							**2**
Buckley	2							**2**
Cardigan	2							**2**
Chepstow	2							**2**
Clydach	1							**1**
Coedffranc	3							**3**
Coedpoeth	1							**1**
Conwy	3					2		**5**
Cwm Gwaun					1			**1**
Cwmllynfell					1			**1**
Dyffryn Clydach	1							**1**
Flint	3							**3**
Gorseinon	3							**3**
Guilsfield							1	**1**
Gwernymynydd	1							**1**
Henfynyw						1		**1**
Kidwelly	2							**2**
Llanarmon yn Ial	2				1			**3**
Llandegla	2							**2**
Llandinam	2							**2**

COMMUNITY/TOWN COUNCILS (continued)

Community/Town Council	Decision Not to investigate	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Llanelli	2						2	**4**
Llangattock	1							**1**
Llangynwyd Lower	5							**5**
Llantrisant	1							**1**
Maenclochog	1							**1**
Maesteg	1							**1**
Manorbier	11			3	2			**16**
Monmouth	5							**5**
Mostyn	1							**1**
Mumbles				1				**1**
Newcastle Higher	1							**1**
Old St. Mellons	4							**4**
Onllwyn	1							**1**
Pontyclun	9							**9**
Resolven	1							**1**
Saltney	1							**1**
St Asaph	1							**1**
St Brides Major	5			2				**7**
Taffs Well and Nantgarw	1							**1**
Tenby	1							**1**
Tintern	5							**5**
Towyn & Kinmel Bay	6			2	1		3	**12**
Tredegar	1							**1**
Ystradgynlais	3							**3**
Total	**113**		**1**	**11**	**6**	**3**	**7**	**141**

POLICE AUTHORITIES

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

Annex D

Extract from Strategic Plan 2009/10 to 2011/12
Vision, Values, Purposes and Strategic Aims

Our vision

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

Our values

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

Our Purposes

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

Strategic Aims

Strategic Aim 1: To raise awareness of our service so that people understand what we do, and that all who need it can access it and make use of it.

Strategic Aim 2: To have in place high quality complaints handling processes, which consider and determine complaints thoroughly but proportionately, and convey decisions clearly.

Strategic Aim 3: To work with public bodies in Wales so that better quality public services are provided as a result of the lessons that can be learnt from the complaints we investigate.

Strategic Aim 4: To demonstrate that our resources are efficiently and effectively deployed.

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

Tel: 01656 641150
Fax: 01656 641199
E-mail: ask@ombudsman-wales.org.uk
Web: www.ombudsman-wales.org.uk

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