Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

MAKING COMPLAINTS **SERVE WALES**

ANNUAL **REPORT** 2014/15

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

The Annual Report 2014/15

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

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1. Introduction by the Ombudsman

Nick Bennett
Ombudsman
(from August 2014)

Margaret Griffiths
Acting Ombudsman
(to July 2014)

I am delighted to introduce this report for the year 2014/15. It is the ninth Annual Report of the Public Services Ombudsman for Wales (PSOW) since the inception of the office in April 2006. The year 2014/15 was of course a year of transition. I took up my appointment as Ombudsman in August 2014, succeeding Professor Margaret Griffiths who was the Acting Ombudsman to July 2014, having been in that role from December 2013. I wish to pay tribute to Professor Griffiths for so ably taking on the interim role as Ombudsman as well as for her assistance and support to me during the transition phase. I valued this highly.

Innovation

On taking up my role, one of the first things that struck me was the stark reality that the volume of increases in enquiries and complaints made to this office reported in previous Annual Report was continuing into 2014/15. Significant was the fact that during July 2014, the month before I took up my post, the office received both the highest number of enquiries and the highest number of complaints since the office came into existence in April 2006. At the end of the year the picture was that, compared with 2013/14 there had been a 7% increase in all contacts (that is, enquiries, public body complaints, and complaints about the conduct of members of local authorities).

Taking a look back over the past five years, complaints about NHS bodies (which includes health boards, GPs, Dentists) have risen by 126%. Whilst not painting such a dramatic picture, it should not go unremarked that complaints about county/county borough councils are also on the rise. Again comparing the position to five years ago, there has been a 10% increase. Greater detail on the complaints made to my office during 2014/15 can be found at section 3 of this report.

This upward trend in contacts to my office has been a matter of concern to me. Whilst admirable work has been undertaken in recent years to streamline the office's complaints handling processes, I have been eager that we should seek to identify areas for further efficiency gains. I therefore instigated an innovation project, which took place over the space of some three months. This engaged all staff. The work resulted in over 30 agreed action points. The majority of these related to internal changes, with a key focus being on reinforcing and gathering greater momentum in relation to becoming a 'paperless office'. We have taken the view that this approach will enable us to gain further efficiencies in relation

to the practicalities of dealing with casework documents. However, there will also be implications for bodies within jurisdiction too and I was able to announce in February the fact that we would be changing our approach so that we would request records in electronic format only, but that associated with this I would be reducing the timescales allowed for bodies in jurisdiction to provide me with the records requested. It is also intended to increase use of Skype/videoconferencing to conduct interviews across Wales.

Turning the Curve

In addition to the changes emanating from the innovation work, I am firmly of the view that we should engage more directly with county/county borough councils and health boards with the aim of promoting improvements in their approaches to complaint handling. These two sectors account for 83% of the complaints that I receive. Essentially the service I provide is reactive. That is, I have to respond to the enquiries and complaints that arrive at my office. However, I am keen that more people's grievances are properly addressed and resolved at local level, providing earlier resolution for complainants and in turn reducing the level of complaints arriving at my door. The current upward trajectory of complaints to my office cannot be sustained indefinitely without additional resource and I am anxious that we should act proactively to turn the curve.

Furthermore, I am of the view that we also need to do more in relation to having a greater wider impact in relation to improving public service delivery and contributing to public policy in Wales, beyond seeking improvement in the place where the problem occurred. I believe that beyond the 'common good' resulting from this, it will also ultimately lead to fewer complaints coming to the office. As part of this programme, I will be placing greater emphasis on my office's own data gathering in relation to the complaints we receive in the office, so that we can derive more detailed statistical data and hence intelligence in relation to the trends and patterns of these.

I have also given considerable thought as to how my staffing resource should be structured in order to enable me to achieve those things that I see as my priorities. Having arrived at my conclusions, I presented my proposals to my staff during March 2015. I will be seeking to implement those changes in the early part of 2015/16.

Assembly Inquiry into the Powers of the Public Services Ombudsman for Wales

Another aspect that I gave early attention to upon taking up my role as Ombudsman was to consider whether the PSOW Act required review, particularly since it is now ten years old. I took the advantage as part of my 'induction' as Ombudsman to ascertain what best practice looked like amongst colleague ombudsmen, particularly within the UK but also further afield. Having considered what I found, I arrived at the view that whilst the PSOW Act remained well regarded within the ombudsman community, there was a danger that Wales would be left behind as regards developments taking place in other nations and countries. Furthermore, I believe it is important to future proof the Act to enable me, and my successors, to be able to respond to the challenges we know Wales will face with the future ageing society.

Building on the work of the previous Ombudsman, Peter Tyndall, I therefore put forward a number of proposals to the National Assembly for Wales in relation to areas where I believed that the current Act could be extended and strengthened. I was exceptionally pleased that the Assembly's Finance Committee agreed to undertake an inquiry into the possibility of extending the powers of the Public Services Ombudsman for Wales. I was delighted that so many stakeholder organisations took the time and trouble to provide evidence. This ranged from bodies in jurisdiction and their representative organisations, the Commissioners in Wales, as well as colleague Ombudsmen in other parts of the United Kingdom and academic experts in the field. At the time of writing, we await the Finance Committee's decision as to whether to recommend the introduction of a Bill in relation to the PSOW's powers.

Thanks

Finally, I wish to thank the staff of my office. Upheaval is never easy, but their professionalism and dedication is of the highest order.

Nick Bennett
Ombudsman

2. My Role as the Public Services Ombudsman for Wales

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

Complaints about public service providers

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

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

Since 1 November 2014, I am also able to consider complaints about privately arranged or funded social care and palliative care services.

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

Code of Conduct Complaints

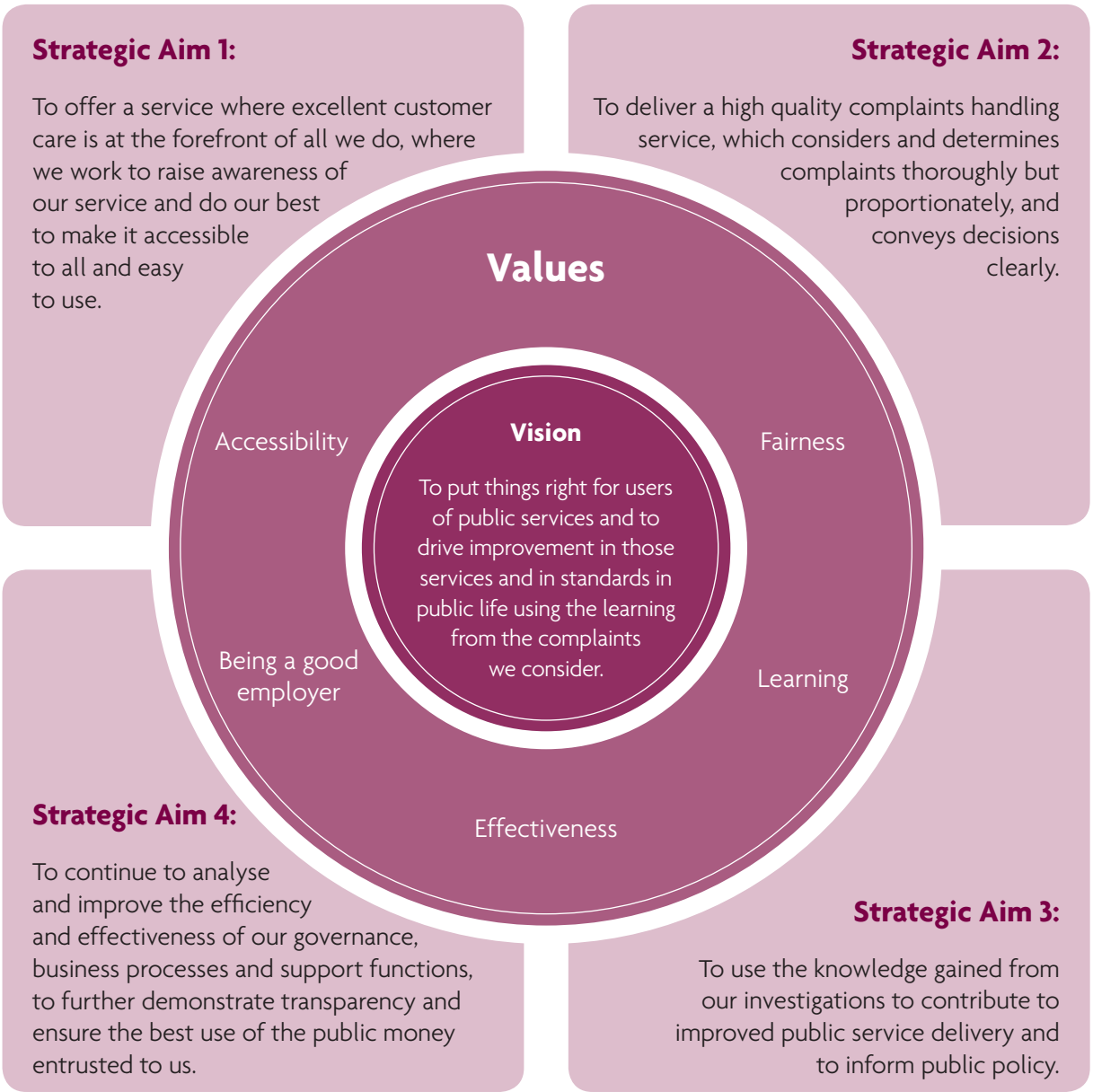
Under the provisions of Part III of the Local Government Act 2000 and also relevant Orders made by the National Assembly for Wales under that Act, I consider complaints that members of local authorities have breached their authority's Code of Conduct. I can consider complaints about the behaviour of members of:

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

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

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

Vision, Values and Strategic Aims



3. The Complaints Service

3,470 Enquiries

7% increase on 2013/14

Total Complaints

2,296

6% increase on 2013/14

Complaints about a **Public Body**

2,065 Complaints

7% increase on 2013/14

938 County Council Complaints

5% increase

769 NHS body Complaints

1% increase

These account for **83%** of all Public Body complaints

Code of **Conduct**

231 Complaints

1% increase on 2013/14

125 County Councillors Complaints

13% increase

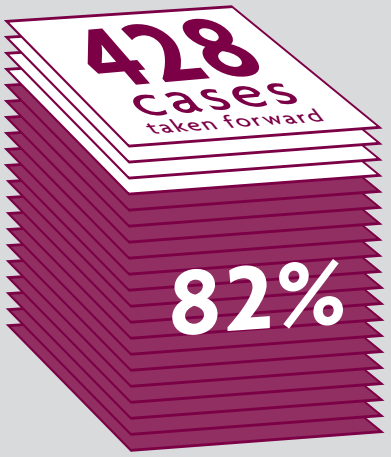
106 Community Councillors Complaints

8% decrease

These account for **100%** of all Code of Conduct complaints

Public Body complaints outcomes 2014/15

Total cases closed: **2,015**

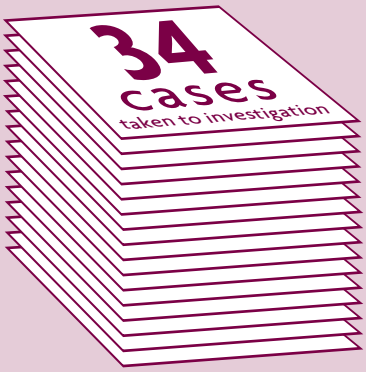


349
complaints upheld /partly upheld

12 of these were **public interest**

Code of Conduct complaints outcomes 2014/15

Total Code of Conduct cases closed: **239**



17 No evidence of a breach of the Code of Conduct

8 No action needed

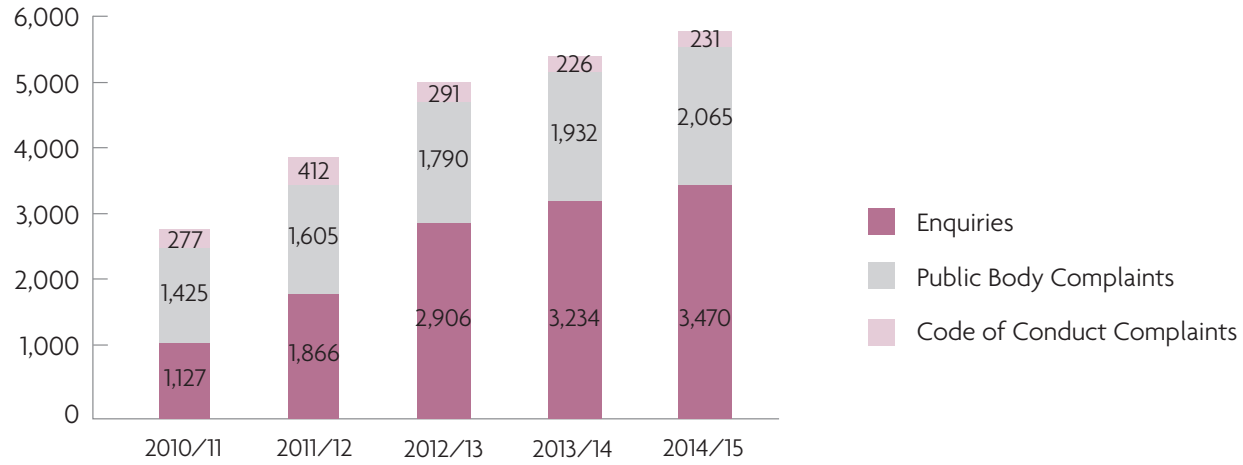
1 Referred to the Adjudication Panel for Wales

8 Referred to a standards committee

Caseload overview

Annual Reports of previous years have drawn attention to the volume of increases in enquiries and complaints to this office. The year 2014/15 saw that trend continue. There was a 7% increase in all contacts (that is, enquiries, public body complaints, and complaints about the conduct of members of local authorities) and casting an eye over the past five years, there has been a 104% increase.

Total Enquiries and Complaints received by year



Enquiries

The office dealt with 3,470 enquiries during 2014/15, compared with 3,234 the previous year an increase of 7%.

Enquiries are contacts made by potential complainants asking about the service provided, which do not, in the end, result in a formal complaint being made to me. At this point of first contact, we will act in various ways, such as:

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

We are pleased that despite the continued increase in enquiries to this office we have been able to provide a prompt service at the frontline. We set ourselves the target of answering our main line reception calls within 30 seconds in 95% of cases. There were 6,307 main line calls to the office during 2014/15 and 99% of these were answered within this timescale, which clearly is better than the target we set ourselves.

Public Body Complaints

The number of complaints received about public bodies continues to increase. We received 2,065 such complaints in 2015/16 compared with 1,932 in 2013/14 (a 7% increase).

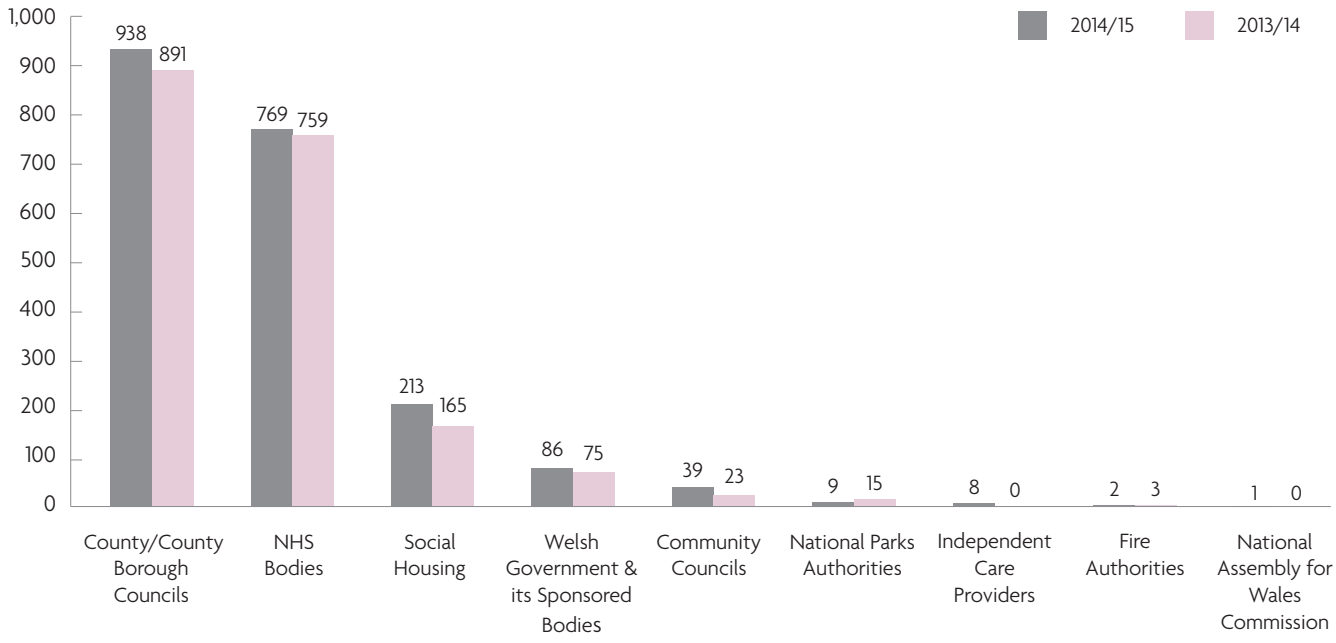
Sectoral breakdown of complaints

County councils have always generated the most complaints to this office. This is not surprising given the wide range of services they provide. For a number of years complaints received about county councils had held at a fairly constant level, the past two years have seen an increase. In particular, there was a notable 5% increase in complaints over the position for 2013/14.

Health body complaints continued the upward trend of recent years. There was a 1% increase over the past year (769 complaints compared with 759 in 2013/14).

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

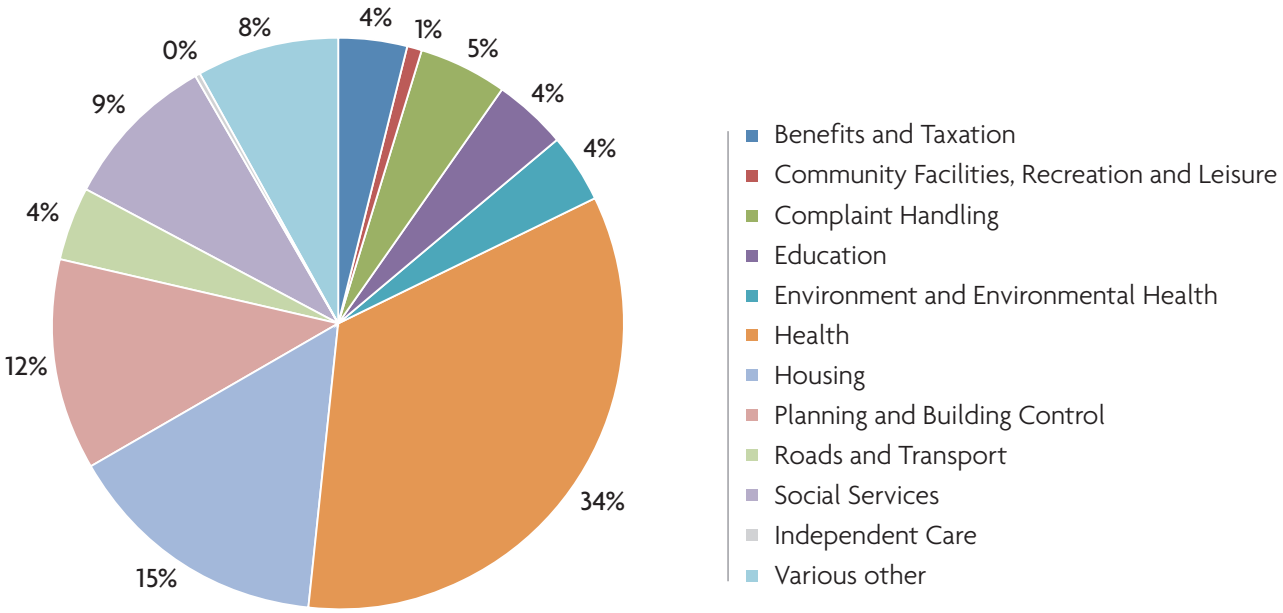
Complaints by public body sector



Complaints about public bodies by subject

As can be seen from the chart below, health complaints account for 34% of the caseload compared with 36% in 2013/14. This small decrease in ratio terms is due to an increase in other types of complaints received rather than a fall in the number of health complaints received (as confirmed by the details above). As has been the case in recent years, housing (15%) and planning (12%) are the service areas which account for the greatest number of complaints received after health complaints.

Complaints by subject 2014/15



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

Outcomes of complaints considered

We closed 2,015 complaints during 2014/15, compared with 1,926 during 2013/14 (an increase of 5%). A summary of the outcomes is set out in the table below and detailed breakdowns of the outcomes by public service provider can be found at Annex B.

I am extremely pleased that we have managed to achieve this level of closure during the year and that we are continuing to keep apace with the increased number of complaints to the office. Whilst the number of cases on hand at the end of 2014/15 stood at 446, compared with 393 at the end of 2013/14, I remain satisfied that this is a reasonable caseload to have open at any one time and do not consider this to be a backlog.

Complaint about a Public Body	**2014/15**	**2013/14**
Closed after initial consideration*	1,564	1,402
Complaint withdrawn	23	47
Complaint settled voluntarily (includes "quick fix" of 127 cases)	164	214
Investigation discontinued	8	18
Investigation: complaint not upheld	71	63
Investigation: complaint upheld in whole or in part	173	173
Investigation: complaint upheld in whole or in part – public interest report	12	9
Total Outcomes – Complaints	**2,015**	**1,926**

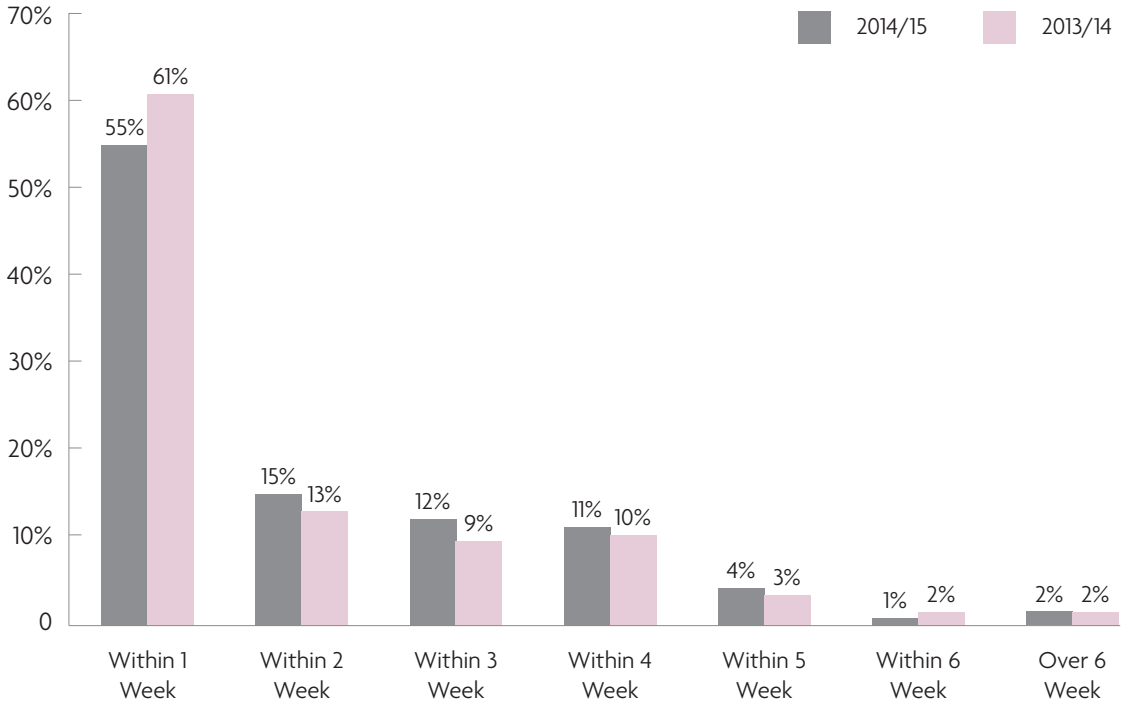
[* Cases closed after initial consideration include complaints that relate to one of the following circumstances:

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

Decision times

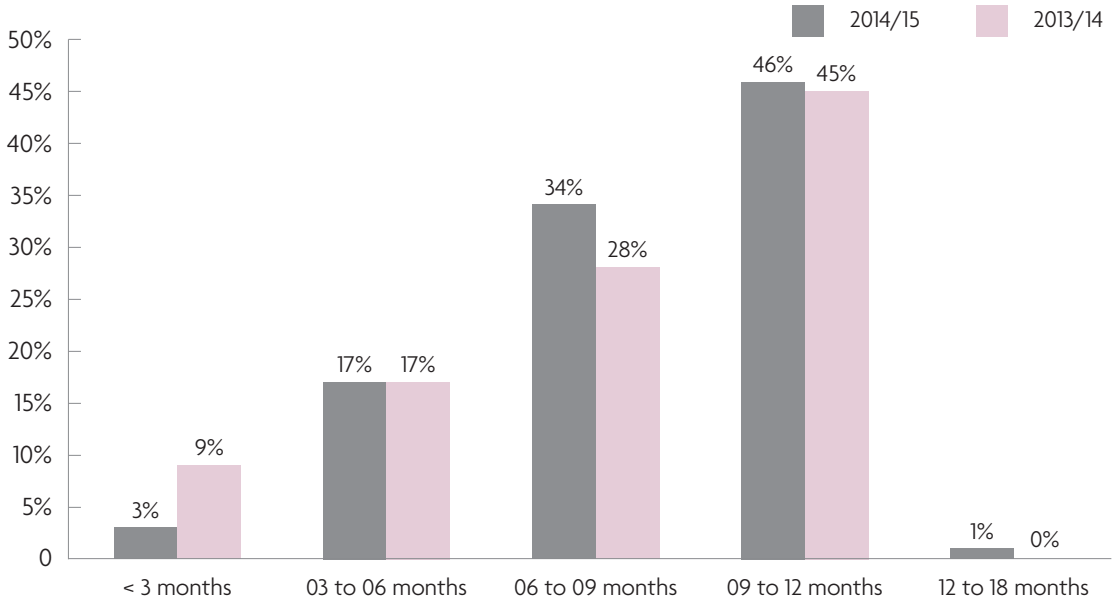
Time taken to tell the complainant if I will take up their complaint

In relation to complaints about public bodies, we informed 93% of complainants within 4 weeks of whether I would take up their complaint (from the date that sufficient information is received). This is better than the 90% target we set ourselves. Further information on these timescales is set out in the chart below.



Investigation Times

We completed 99% of investigations within 12 months, against the 100% target we set ourselves. There were two cases that went over 12 months. Both of these involved strong challenges from parties in the investigation. This led to further clinical advice being sought in the first case, and an internal review of the evidence gathered in the second before the investigation could be concluded. The chart below gives further details on the timescales taken to conclude investigations concerning public bodies.



Code of Conduct Complaints

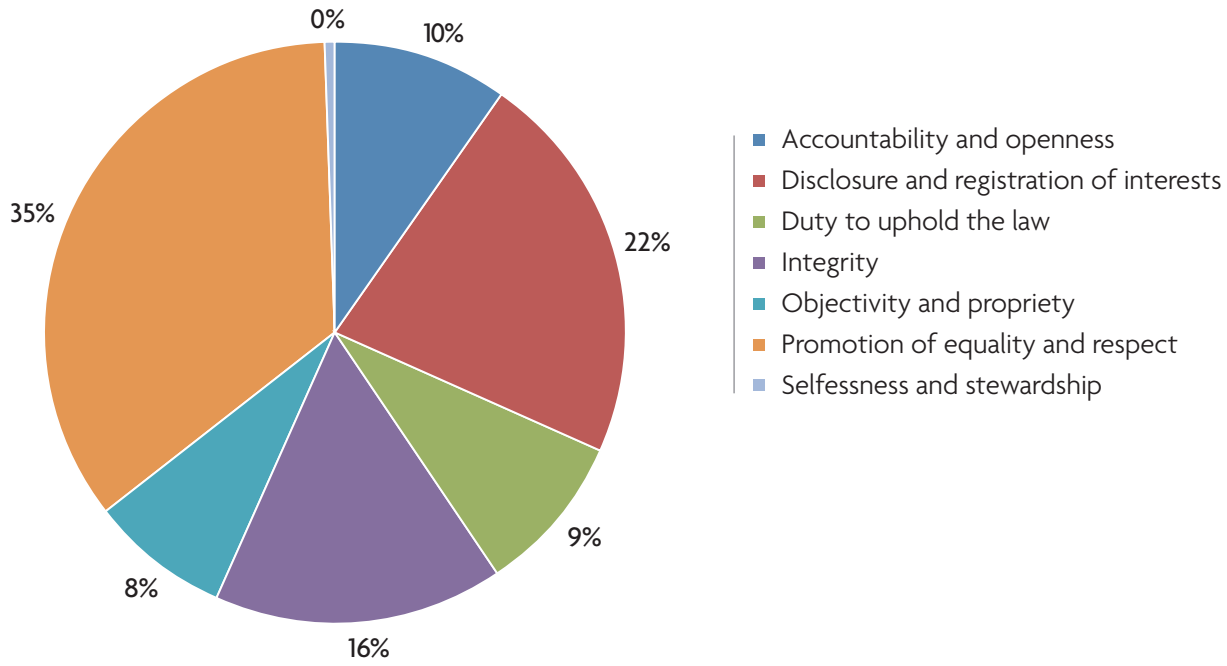
Complaints received

Overall the number of number of complaints received was similar (231 in 2014/15 compared with 228 in 2013/14). However, the past year saw an increase in complaints about members of county or county borough councils, whilst the number of complaints concerning members of community councils fell. This can be seen in the table below.

	2014/15	2013/14
Community Council	106	115
County/County Borough Council	125	111
Fire Authority	0	2
National Park Authority	0	0
Police & Crime Panels	0	0
Total	**231**	**228**

Nature of Code of Conduct complaints

As in previous years, the majority of complaints received during 2014/15 related to matters of 'equality and respect'. In 2014/15 this accounted for 35% of the code of conduct complaints received compared with 36% in 2014/15. The next largest areas of complaint related to disclosure and registration of interests (22%), and integrity (16%).



[Note: Although showing as '0%' there was 1 complaint made in relation to 'Selflessness and stewardship']

Code of Conduct complaint outcomes

Of the 239 Code of Conduct complaints closed in 2014/15, the majority (178) were closed under the category 'Closed after initial consideration'. This includes decisions such as:

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

A greater number of investigation reports were referred either to a local authority's standards committee or to the Adjudication Panel of Wales in 2014/15 (9 complaints) compared with 2013/14 (6 complaints). In these circumstances it is for these bodies to consider the evidence found, together with any defence put forward by the member concerned. It is then for them to determine whether a breach has occurred and, if so, what penalty, if any, should be imposed.

A summary breakdown of the outcomes is below:

	2014/15	2013/14
Closed after initial consideration	178	176
Complaint withdrawn	7	12
Investigation discontinued	20	8
Investigation completed: No evidence of breach	17	10
Investigation completed: No action necessary	8	17
Investigation completed: Refer to Standards Committee	8	5
Investigation completed: Refer to Adjudication Panel	1	1
Total Outcomes – Code of Conduct complaints	**239**	**229**

County councillors are now expected to make their complaints about other councillors within their authority to their monitoring officer. However, I continue to receive 'low level' complaints of this type at my office. These, for example, could be allegations of failures to show respect and consideration of others under paragraph 4(b) of the code. We have reviewed our practice in dealing with the complaints of this type that come to my office, and will be taking a firmer position in the future in referring these 'low level' complaints back to monitoring officers to be dealt with locally.

A detailed breakdown of the outcome of Code of Conduct complaints investigated, by authority, during 2014/15 is set out at Annex C.

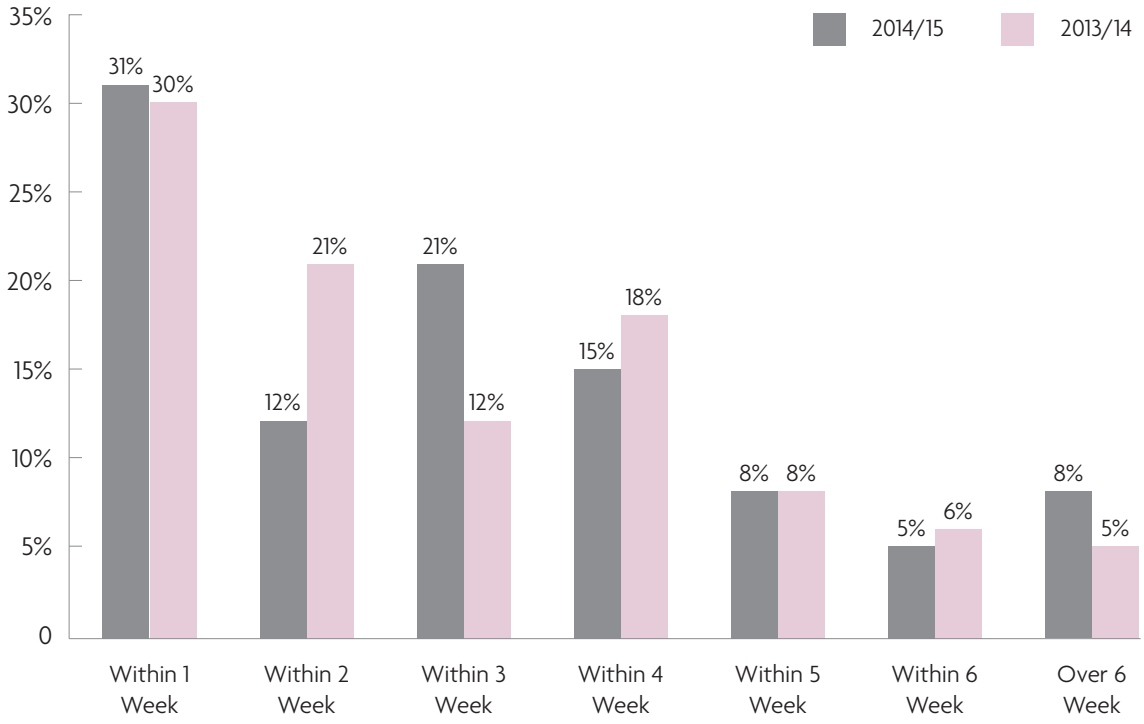
Decision times

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

In respect of Code of Conduct complaints, 79% of complainants were informed within 4 weeks of whether I would take up their complaint (from the date that sufficient information is received). This is lower than the 90% target we set ourselves.

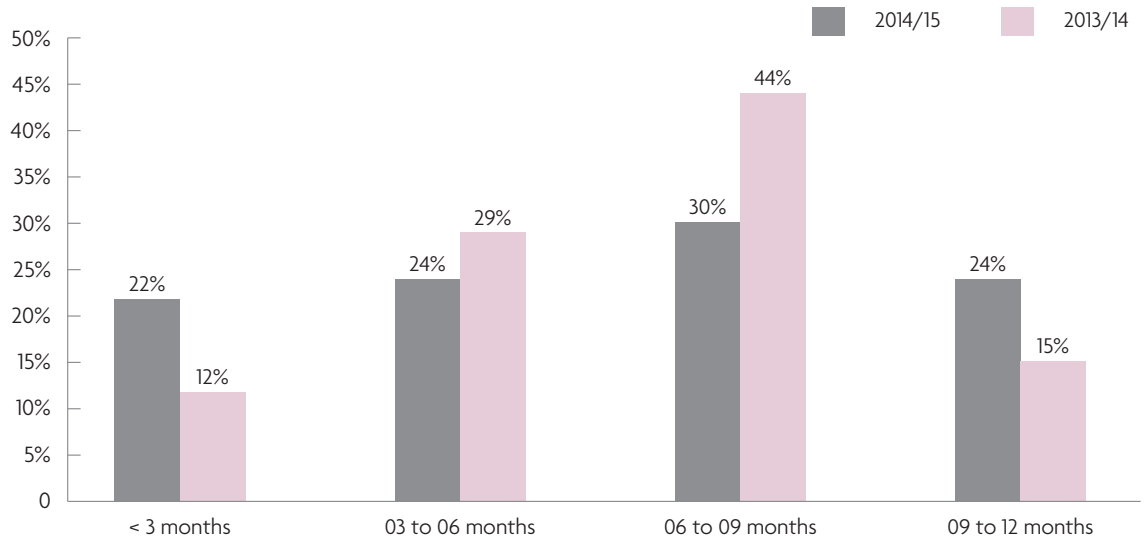
However, different from the position in relation to public body complaints, although not obliged to, members may (and often do) comment on the complaint against them when they have been informed of the complaint. Whilst therefore it can take longer to decide whether to commence an investigation, I consider that it is fairer for us to take into consideration what a member has to say before taking a decision. This is because the commencement of a formal investigation against a member is a stressful and serious matter for the member being complained about. Nevertheless, I will work during the year to ensure that we advise both the complainant and the accused member promptly as to whether we will take the matter into investigation or not.

Further details on these decision timescales are shown overleaf.



Investigation Times

The position for completing code of conduct investigations is a positive one. I am pleased that over the past year we succeeded in meeting our 100% target for completing investigations within 12 months, as can be seen in the chart below.



4. Improving Public Service Delivery

I place great importance on using the knowledge and learning gained from the casework of my office to improve public service delivery in Wales and to inform public policy. There are a number of established key vehicles in place in this regard:

- **Public interest reports – 12 issued in 2014/15:** Summaries of these complaints together with findings and outcomes are set out at Appendix A, with the full reports available on my website at www.ombudsman-wales.org.uk.
- **The Ombudsman's Casebook, which is published quarterly:** Key issues addressed during 2014/15 were -
  - failures by local authorities to recognise their homelessness duties and associated handling of housing application
  - insufficiently robust investigations by public service providers, inconsistent with the mantra of 'investigate once; investigate well', together with missed opportunities by service providers to resolve matters themselves at an early stage.
- **The Code of Conduct Casebook:** Last year it was reported that a Code of Conduct Casebook had been introduced on a biannual basis at the request of local authority monitoring officers. This has been well received, but a request was made during the year for this be produced on a quarterly rather than six monthly basis. Quarterly editions will therefore appear in 2015/16, however, due to the low number of cases available within quarterly editions, a commentary/lessons learnt section will be produced within an end of year 'annual compendium' only.
- **Annual letters – county councils and health boards:** Published on my website, these provide details in respect of the individual bodies and comparisons against other organisations in the same sector as well as details on an All Wales basis. They are also used as the basis of discussions with the Chairs and Chief Executives of individual local health boards. Local authorities are also invited to seek a meeting to discuss their particular Annual Letter if they so wish.

In addition to the above, a revised edition of the **Guidance on the Code of Conduct for local authorities members,** originally published in 2010, was issued at the end of March 2015. A key change introduced is the new 'public interest test' that I will now apply when considering whether or not to investigate a complaint. I have introduced this test as a result of the high number of trivial complaints that I receive at my office, and to make clear the criteria that I will apply when considering whether a complaint should be taken into investigation or not. This test will ensure that I continue to investigate serious complaints to maintain public confidence in standards of public life. Other changes introduced into the document include further guidance on the use of social media and political expression, as well as a flowchart designed to provide members with assistance on the issue of interests. I hope these changes will also see a reduction in the number of code of conduct complaints to my office. The revised version of the Guidance can be found on my website: www.ombudsman-wales.org.uk

I have also given consideration to how I might be able to work with other relevant organisations. Examples of activities during 2014/15 have been:

- **Information Commissioner**

I have been very pleased to be able to work with the Information Commissioner in reviewing the PSOW's Principles of Good Administration. At the time of writing the proposed revised document is out to consultation, but the intention is to introduce two new principles in relation to Good Records Management and to issue the revised version as a joint publication with the ICO.

- **Commissioners in Wales**

I have continued to meet regularly with the Commissioners in Wales to discuss matters of mutual interest and concern. We continue to explore ways in which we can reinforce each other's work for the benefit of public services in Wales. For example, I intend in the forthcoming year to give consideration to the issue of the apparent lack of social care complaints that I receive, in view of the outcome of the Older People's Commissioner's "A Place to Call Home?: Care Home Review Report". In addition, I was delighted to have had the opportunity to speak at an event hosted by the Welsh Language Commissioner during the National Eisteddfod for Wales in 2014, in what was my first week in the post as Ombudsman. I was also grateful to the Commissioners for their support for the proposals for new legislation and was encouraged by the recognition that our respective offices could work well together in relation to any proposed own initiative investigations, should the Ombudsman be granted this power by the Assembly.

- **Memorandum of Understanding (MoU) with the Care and Social Services for Inspectorate Wales (CSSIW)**

Whilst the CSSIW is a body within my jurisdiction, I considered that it would be appropriate to put in place a MoU with the CSSIW in view of its role as a regulator. The MoU was signed on 14 December 2014 and was particularly timely in view of the recent extension to my jurisdiction on 1 November 2014 to be able to consider complaints about privately arranged or funded social care and palliative care services.

In the forthcoming year, I will be looking to explore how the work of my office can have a greater impact in the future in relation to influencing improvements in public service delivery and for informing public policy and I look forward to being able to report next year on developments in this area.

5. Governance and Accountability

The Ombudsman

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

During 2014/15, I appeared before three of the Assembly's Committees, namely the Public Accounts Committee (to discuss the Annual Accounts for 2013/14); the Communities, Equality and Local Government Committee (to discuss the Annual Report for 2013/14); and the Finance Committee (to discuss my budget estimate submission for 2014/15). I welcomed the opportunity on each occasion to discuss how the public money I received was and would be spent, and the service provided by my office.

Advisory Panel and Audit & Risk Assurance Committee

Whilst bearing in mind the constitutional position of a corporation sole, I have an Advisory Panel which provides both challenge and support to me as Ombudsman. There is also an Audit & Risk Assurance Committee, a sub-committee of the Panel, which provides particular support to me in relation to my responsibilities as Accounting Officer. The work of both these fora over the past year will be addressed in greater detail as part of the Governance Statement within my Annual Accounts for 2014/15, which I expect to be published in August 2015. However, I take the opportunity here to state that, following an open recruitment exercise, I was delighted that Mrs Sharon Warnes, previously Assistant Director/Senior Policy & Performance Manager at Gwynedd Council, was appointed to the Advisory Panel (following Mr Ceri Stradling's resignation at the end of 2013/14). Mrs Warnes also sits on the Audit & Risk Assurance Committee.

Management Team

Whilst as Ombudsman I am solely accountable for the decisions and operation of my office, the Management Team is a formal group that provides me with advice and support. It takes specific responsibility for advising on the development of the three year Strategic Plan and the annual Business Plan; annual budgetary requirements; ensuring the best use of the public money received; and an appropriate performance monitoring framework.

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

Three Year Strategic Plan and Business Plan

The past year was the final year in relation to implementation of the Strategic Plan developed for 2012/13 to 2014/15 and many of the activities and achievements have been reflected in this Annual Report. The existing vision, values, purposes and strategic aims for the PSOW service can be found at page 9.

I decided during the course of the year to produce a one year Strategic Plan for 2015/16, which has been deliberately rolled on from the previous Three Year Strategic Plan as I believe that the 'Vision' remains as relevant and appropriate as ever, not least given the current public policy context. Another key consideration for rolling on the previous three year Strategic Plan for a further year was that it was hoped that the National Assembly for Wales would agree to modernising the PSOW Act. It seemed more appropriate for the office to develop a new Three Year Strategic Plan at a time when the position on these potential changes to the Ombudsman's legislation is known.

European Directive on Alternative Dispute Resolution

Following the issuing of the European Directive on Alternative Dispute Resolution, the UK Government laid before Parliament on 17 March 2015 the Alternative Dispute Resolution for Consumer Disputes (Competent Authorities and Information) Regulations 2015. These new arrangements in relation to consumer and trader disputes have an impact on PSOW jurisdiction in relation complaints about independent care providers.

Whilst the National Assembly for Wales has legislated that people who fund their own care have a right to complain to the Ombudsman, the EU Directive/UK Regulations will mean that unless the PSOW applies (at a cost) to be an 'ADR Entity' the UK Government will also nominate an alternative ADR entity to be available to consider such grievances. That said, neither the EU's ADR Directive nor the UK Government's Regulations make ADR compulsory for businesses in areas where it is not currently, so the majority of businesses will retain a choice as to whether to use an alternative ADR entity or not. Further they would no doubt be the subject of a charge to sign up to an alternative ADR provider. This ultimately means that the only statutory right that service users will have, in relation to the independent consideration of their complaint to an independent care provider, will be through the Ombudsman.

There are a number of issues requiring consideration in this matter, including questions of subsidiarity, and the position of the Ombudsman in relation to accountability to the National Assembly for Wales and independence as regards reporting to the UK Government's nominated Competent Authority – the Trading Standards Institute, in what in essence is a 'traders' membership organisation'. There is also the issue that independent social care providers are organisations which are regulated by the CSSIW. At the time of writing, I am still considering whether or not it is appropriate for the PSOW to apply to be an ADR entity.

6. Other Activities

Relationship with the National Assembly for Wales

Welcoming the Presiding Officer to our office

I am pleased with the development of the relationship between my office and the National Assembly over the past year. I was pleased to meet with Dame Rosemary Butler, the Presiding Officer, in the early days after having taken up my appointment and to be able to discuss my initial priorities as Ombudsman. I was also delighted to be able to welcome the Presiding Officer to my office in January 2015, when Dame Rosemary took the time to meet individual members of my staff. This was much appreciated.

I refer elsewhere in this report to my engagement with the Assembly in relation to the inquiry into the powers of the Ombudsman. I have been very grateful to Mrs Jocelyn Davies, AM, the Finance Committee Chair and all members of the Finance Committee for agreeing to undertake this inquiry and for being prepared to consider recommending a Committee led Bill in this regard. I know that my officers too have appreciated the co-operation they have received from Assembly staff in this regard.

I was also pleased to be able to offer as part of the professional development scheme for Assembly Members and their staff, a training session whereby we were able to discuss the work of my office tailored in a way in order to assist them to be able to better advise their constituents about what, as Ombudsman, I can and cannot do.

Outreach

The office's stakeholders are many, and include

- members of the public (i.e. the users of public services)

- bodies within jurisdiction

- members of the National Assembly for Wales

- voluntary organisations (in particular those who offer advocacy services)

- the media.

We have continued in our endeavours to help people know where and how to put a complaint about a public service through the Complaints Wales signposting service, which is delivered by the Complaints Advice Team. This independent and impartial web and telephone service signposts people's complaint to the organisation that provides the service they wish to complain about, or to the appropriate independent complaint handler or ombudsman. Promotion of the service continued during 2014/15 via a radio advertisement campaign.

In relation to bodies in jurisdiction, in addition to the meetings held with individual bodies, during January 2015 I held regional seminars aimed at both chief executives and complaint handling practitioners, where the issue of good practice in relation to complaint handling and records keeping was addressed. I was grateful to a number of complaint handling practitioners from bodies in jurisdiction for speaking about their experiences at these sessions. I was particularly pleased that over 200 people attended from all sectors within my jurisdiction.

Delegates in attendance at the seminar held in Newport.

We continued to engage with voluntary organisations. For example, during the past year we spoke at, or held meetings with Oxfam Cymru, Diverse Cymru, All Wales Credit Union Managers Group, Shelter Cymru, Age Cymru, Welsh Council for Voluntary Action and the Motor Neurone Disease Association. We also held meetings with, or spoke at events held by, professional and representative bodies of those delivering public services (for example, law and nursing professions; One Voice Wales).

A positive relationship with the media continued. Media attention to the work of the office again was largely as a result of the public interest reports issued. However, I was also pleased to be able to meet with BBC news and current affairs staff during the year. It was particularly useful to be able to discuss the limits of what I am able to comment upon as Ombudsman and what is and is not possible to put into the public domain as a result of the confidential work of my investigations.

Complainant satisfaction research

We have continued with our complainant satisfaction survey practice in relation to customer satisfaction for our first contact service. The outcome for 2014/15 was as follows:

	% of respondents answering either 'strongly agree' or 'agree'
It was easy to find out how to contact the Public Services Ombudsman for Wales	84%
The service I have received has been helpful and sensitive	75%
Staff were able to understand my complaint / The person that dealt with my query knew enough to be able to answer my questions	73%
I was given a clear explanation of what would happen to my query/complaint	80%
The service has provided what I expected of it	64%

The past year has again overall seen a very good level of satisfaction. Also similar to previous years, responses to the final question have been affected by a decision by the Ombudsman not to investigate their complaint, for example, because the person concerned has not yet complained to the organisation concerned or that the matter is outside of the Ombudsman's jurisdiction. Sometimes, people decline to answer this question, saying that they are going to wait for the Ombudsman's decision on their complaint.

In addition, the data gathered from the questionnaires returned to us, which contain both satisfaction and equality information, is now input into our complaints handling system and associated with the relevant complaint case record. This has enables us to analyse outcomes of complaints against various protected characteristic groups. This work is still in its infancy, but I am pleased that to date nothing has emerged from this analysis to suggest that there should be any reason for concern in relation to anything in our processes or approach to investigations which disadvantage any particular groups of people. (Note: access to the customer satisfaction and equality data on our system is limited to a couple of members of staff and no complaint handler has access to these details.)

The PSOW and the Ombudsman World

The 9th Regional Seminar of the European Network of Ombudsmen

The PSOW, jointly with the European Ombudsman, hosted a very successful three-day seminar in June. The event was very well attended by regional ombudsmen from across Europe. The theme was 'Voices for the Voiceless' and seminar sessions were relevant to all participants and provided much food for thought among the delegates. It was interesting to note that we all faced similar challenges. It was also an opportunity to showcase Wales to those present. On behalf of Margaret Griffiths as well as myself, I would like to thank Dame Rosemary Butler, the Presiding Officer, for hosting the welcome reception at the Senedd.

Emily O'Reilly, European Ombudsman (standing) and Acting Ombudsman, Margaret Griffiths, addressing the European delegation.

International Ombudsman Institute/Northern Ireland Ombudsman

In July 2014 the Northern Ireland Ombudsman and Northern Ireland Human Rights Commission (NIHRC) produced a Human Rights Manual which is a toolkit for ombudsman staff to identify human rights issues in the assessment and investigation of complaints of maladministration. This was launched by them at the IOI World Conference in Tallin. The Northern Ireland Ombudsman and the NIHRC have committed to deliver a training package to enable other ombudsman schemes to develop a human rights based approach to investigations of maladministration. Whilst my office has already adopted such an approach to a certain degree, I am pleased that arrangements have been made for the training on the toolkit to be delivered to my staff in the early part of 2015/16.

The Ombudsman Association

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

Complaints about the PSOW service

The 'Complaints about us' procedure can be used if someone is unhappy about our service. For example, a complainant may wish to complain about undue delay in responding to correspondence; or feel that a member of staff has been rude or unhelpful; or that we have not done what we said we would. There is a separate procedure for complainants wishing to appeal against a decision on their complaint. Further details about both these procedures are available on my website: www.ombudsman-wales.org.uk.

The table below reports on the number of complaints received during 2014/15 and their outcomes, together with a comparison of the position in 2013/14.

	2014/15	2013/14
Complaints brought forward from previous year	3	2
New Complaints received	13	32
Total Complaints	7	12

Outcomes		
Not Upheld (service related issue)	14	13
Upheld in whole or in part	12	7
Related to investigation decision - referred to investigation process	44	17
Complaint withdrawn or insufficient information	14	7
Total closed during year	**84**	**44**
Ongoing and carried forward at 31 March	1	3

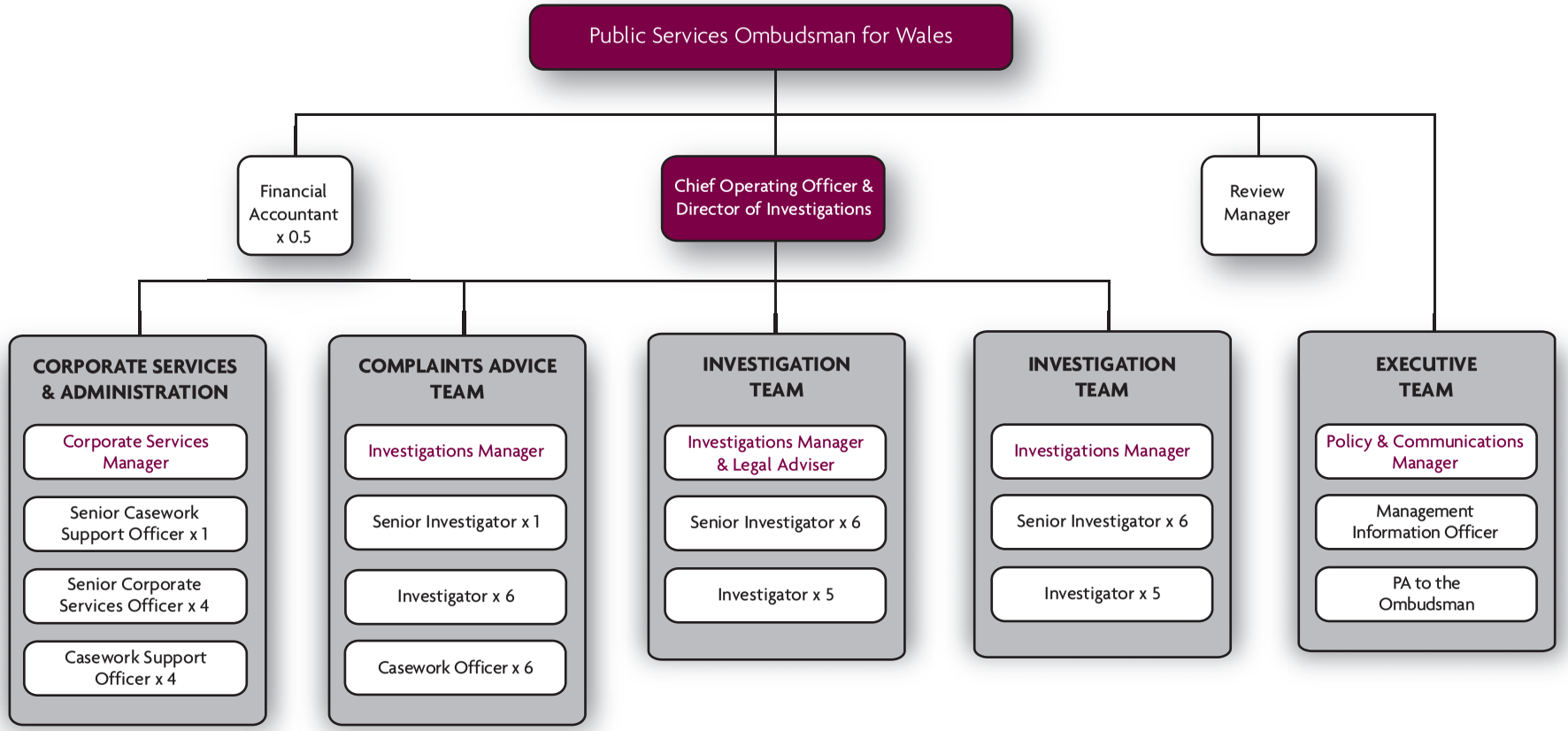
The nature of the complaints that were upheld/partly upheld were:

Undue delay in response	1
Wrong postcode held on file	1
Incorrect information provided	1
Not responding to correspondence	1
Interviews forms and CD recording covers not bilingual	1
Website complaint form submission error	3
Wrong details held on file / or correspondence sent in error	4
Total	**12**

The following corrective action was undertaken:

- An apology was issued to the complainant in all 12 cases.
- The relevant line Manager(s) were made aware of the upheld complaints relevant to their team for future training and monitoring.
- Appropriate and relevant staff training was undertaken where necessary.
- Appropriate action in accordance with PSOW HR policies was undertaken.
- Issues with ITC e.g. Website submissions were reported to relevant IT providers for resolution.
- Interview forms are now available in a bilingual format, and arrangements have been made for bilingual CD labels to be used as soon as they are available.

Organisational Chart (position as at 31 March 2015)



7. Equality Issues

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

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

Accessibility

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

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

During 2014/15, further work was undertaken in relation to our websites, with a view to introducing tools to enable translation of web pages in a whole host of languages; checks in relation to website accessibility issues; introduction of BrowseAloud which functions for the mobile versions of our websites in addition to the desktop versions.

Particular attention has also been given to requirements of those people who are deaf or hard of hearing and we intend to improve on our service in relation to British Sign Language provision and other relevant facilities during 2015/16.

We also recognise that some service users may need assistance in making their complaint to us and we have also invested a great deal of our energy in gathering information about advocacy and advice organisations to help them in this regard. This information is readily available on our website as well as through our Complaints Advice Team.

Equality Data Gathering/Monitoring – Service Users

We have always undertaken equality monitoring in respect of service users, which has informed our annual outreach strategy. Results of equality monitoring undertaken since 2005/06 in respect of service users was published in the Strategic Equality Plan.

The outcome of the monitoring during 2015/16 in respect of the protected characteristic groups (as defined in the Equality Act) is set out below.

In view of the nature of the work of this office, we would expect the composition of people who complain to this office to, at the very least, mirror the national demographic position; in fact, we would expect the proportion of complainants from groups who could be considered to be at disadvantage or vulnerable to exceed the national picture. In respect of each of the questions we asked, those who completed the form were given the opportunity to respond 'Prefer not to say'. Nevertheless, from the results below, the PSOW is relatively satisfied that in making comparisons with official data available (e.g. the Census 2011) the composition of our service users meets or exceeds national demographics in the way we would expect. It is in particular good to see that of those who responded, 4% identified themselves as having a minority ethnic background, which matches the demographic picture in Wales against the Census in 2011. This was a group which was slightly under represented in the most recent few years.

We take the results from our equality monitoring into account when developing our outreach programmes. We gave particular focus to raising awareness of the PSOW service among people from minority ethnic groups during 2014/15, engaging with organisations such Diverse Cymru and Oxfam Cymru. Whilst the improvement could be a matter of coincidence, I believe this outreach work has at least had some impact in this area.

Protected characteristic group	Percentage Outcome
Age:	
Under 25	4%
25-34	13%
35-44	19%
45-54	22%
55-64	20%
65-74	12%
75 or over	5%
Prefer not to say/No response	4%

Protected characteristic group	Percentage Outcome
Disability	
Yes	30%
No	61%
Prefer not to say/No response	9%
Health problem or disability limiting day-to-day activities?	
Yes, limited a lot	26%
Yes, limited a little	15%
No	50%
Prefer not to say/No response	8%
Gender reassignment	
Yes	31%
No	0.5%
Prefer not to say/No response	68.5%
Religion or belief	
No religion	39%
Christian (all denominations)	49%
Other religions	6%
Prefer not to say/No response	5%
Married or same-sex civil partnership	
Yes	46%
No	44%
Prefer not to say/No response	11%
Race/Ethnicity	
White	91%
Other ethnic background	4%
Prefer not to say/No response	5%
Sex	
Male	47%
Female	47%
Prefer not to say/ No response	6%
Sexual orientation	
Heterosexual or straight	84%
Gay or Lesbian	3%
Bisexual	0.5%
Other	1%
Prefer not to say/No response	11.5%

Our Casework

Our commitment and contribution to equality matters also manifests itself in our complaint handling work. We also have regard to matters of human rights. Whilst it is not for the Ombudsman to decide whether a public service provider is in breach of such legislation, it is possible that the failure to take account of any such legal obligations, or to follow policies and procedures designed to implement these obligations, will be maladministration. For example, following the investigation into a complaint about works being undertaken at a property by a housing association, the report issued in January 2015 included a recommendation that the housing association should also consider the impact of its failings in connection with the Human Rights Act.

Training

PSOW staff have over the years received equality and diversity training. We continue to provide relevant training in this regard. This is important to us for two reasons. Firstly, so that in the service we provide we can be responsive to the changing needs and requirements of people with whom we communicate and interact. For example, most recently two members of staff have been learning how to communicate via British Sign Language. Secondly, so that we have the knowledge to be able to identify during our investigations any failings by public service providers in respect of their equality duties.

Further, and as referred to at Section 6 of this Annual Report, arrangements are being put in place for 2015/16 in relation to training for staff to identify human rights issues in the assessment and investigation of complaints of maladministration

Outreach

We meet regularly with third sector organisations, holding formal seminars at least biennially, giving talks and addresses at their conferences and we also have an ongoing proactive programme of meeting with individual organisations. This year's activity has been reported on at Section 6 of this Annual Report. This enables two way discussions about the work of the office, so that we can obtain views on the service we provide from their perspective and it enables us to explain how they can help those individuals who require assistance in making a complaint to us to do so.

Equality Impact Assessments

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

Staff Equality Data Gathering/Monitoring

Our staff have been asked to complete and return a monitoring form seeking information in respect of each of the protected characteristics. We also now gather such information during our recruitment exercises. That disclosure is, of course, on a voluntary basis. The data held at 31 March 2015 is set out below.

Age	The composition of staff ages is as follows: 21 to 30: 17% 31 to 40: 29% 41 to 50: 31% 51 to 65: 23%
Disability	86% of staff said there were not disabled, no member of staff said that they were a disabled person (14% preferred not to say) However, when asked if their day-to-day activities were limited because of a health problem or disability which had lasted, or was expected to last, at least 12 months, 2% said that they were limited a lot, 2% said they were limited a little, 82% said their day to day activities were not limited (14% preferred not to say)
Nationality	In describing their nationality, 50% said they were Welsh; 26% said British, 10% said they were English, 2% said 'Other' (12% preferred not to say)
Ethnic group	The ethnicity of staff is: 79% White (Welsh, English, Scottish, Northern Irish, British); 2% White/Irish 3% Black (African, Caribbean, or Black British/Caribbean 2% Asian or Arian British/Bangladeshi (14% preferred not to say)
Language	When asked about the main language of their household, 75% of staff said this was English; 11% said Welsh, and 2% said 'Other' (12% preferred not to say)
Religion or Belief	Responses to the question asking staff about their religion were as follows: No religion: 38%; Christian 38%; Muslim 2%; Other:1% (21% preferred not to say)
Marriage/ Civil Partnership	When asked if they were married or in a same sex civil partnership, 49% of staff replied 'Yes'; whilst 33% said 'No' (18% preferred not to say)
Sexual Orientation	Responding on this, 77% said that they were Heterosexual or Straight, 2% said Gay or Lesbian (21% preferred not to say)

Under the specific duties we are required to set an equality objective for gender and pay; if we do not do so, we must explain why. The Strategic Equality Plan does not currently contain any specific objective in this regard because at the time of its development females were very well represented at the higher pay scales within my office. The position is kept under continual review and the equality objectives will be revised if necessary. However, as can be seen from the table below, the position currently remains satisfactory.

Pay and Gender - data as of 31/03/2015

Pay (FTE)	Male	Female
Up to £20,000	0	6
£20,001 to £30,000	1	12
£30,001 to £40,000	1	2
£40,001 to £50,000	8	20
£50,001 to £60,000	3	2
£60,001 +	1	1
Subtotal	**14**	**43**
Total	**57**	

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

- 13 members of staff work part time (11 female, 2 male).
- no members of staff were employed on a fixed term contract.

New starters / staff leavers

During the year we have had six members of staff leave and recruited six. Due to the low numbers involved, the equality data for these individuals has been reported as part of the all staff information above. It is not considered appropriate to report separate equality information relating to the individuals involved due to the risk of identification.

Recruitment

During the year we have conducted three recruitment exercises which have resulted in the following data:

		IO	CAT CO / CWSO	Advisory Panel Member	Total
Age	Did not say	9%	8%	0%	9%
	under 25	0%	28%	0%	19%
	25-34	26%	35%	0%	32%
	35-44	29%	19%	0%	22%
	45-54	25%	10%	21%	15%
	55-64	11%	0%	64%	4%
	65-74	0%	0%	7%	1%
	75 and over	0%	0%	7%	1%
Gender	Did not say	4%	3%	7%	4%
	Male	43%	42%	71%	42%
	Female	53%	55%	21%	54%
Nationality	Did not say	5%	6%	7%	6%
	Welsh	92%	61%	64%	71%
	English	3%	9%	0%	7%
	Scottish	0%	3%	0%	2%
	Northern Irish	0%	0%	0%	0%
	British	0%	18%	29%	12%
	Irish	0%	3%	0%	2%
	Welsh/German	0%	0%	0%	0%
Ethnic Group	Did not say	5%	12%	0%	10%
	White(Welsh/Scottish/English/ NI/British)	95%	76%	100%	82%
	White (Irish)	0%	3%	0%	2%
	White (Gypsy/Irish traveller)	0%	0%	0%	0%
	White (Other)	0%	0%	0%	0%
	Asian/Asian British	0%	6%	0%	4%
	Black, African, Caribbean or Black British	0%	3%	0%	2%
	Mixed or multiple ethnic group	0%	0%	0%	0%
	Other ethnic Group	0%	0%	0%	0%
Language	Did not say	14%	3%	14%	7%
	English	18%	92%	57%	67%
	Welsh	58%	0%	29%	19%
	Bilingual (Welsh/English)	10%	5%	0%	7%
	Other	0%	0%	0%	0%

		IO	CAT CO / CWSO	Advisory Panel Member	Total
Disability	Did not say	10%	3%	0%	6%
	Yes	0%	0%	0%	0%
	No	90%	97%	100%	95%
Limited Activities	Did not say	10%	3%	7%	5%
	Yes, limited a little	0%	0%	0%	0%
	Yes, limited a lot	0%	0%	0%	0%
	No	90%	97%	93%	95%
Religion	Did not say	16%	12%	0%	13%
	None	34%	59%	14%	51%
	Christian	47%	29%	86%	35%
	Buddjist	0%	0%	0%	0%
	Hindu	0%	0%	0%	0%
	Jewish	0%	0%	0%	0%
	Muslim	0%	0%	0%	0%
	Sikh	0%	0%	0%	0%
	Other	3%	0%	0%	1%
Married or civil partnership	Did not say	5%	7%	7%	6%
	Yes	32%	16%	86%	21%
	No	63%	77%	7%	72%
Sexuality	Did not say	18%	19%	7%	19%
	Heterosexual	82%	74%	93%	77%
	Gay or Lesbian	0%	7%	0%	5%
	Bisexual	0%	0%	0%	0%
	Other	0%	0%	0%	0%

[Note: the above information excludes internal promotion.]

Key to abbreviations:

- **IO** – Investigation Officer.
- **CAT CO/CWSO** – Complaints Advice Team Casework Officer or Casework Support Officer.

Staff Training

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

Disciplinary / Grievance

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

Procurement

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

Annex A

Public Body Complaints

Public Interest Reports: Case Summaries

Cwm Taf University Health Board
Case reference 201401023 – Report issued March 2015

Mr C complained to me about the care given to his mother (Mrs M) by Cwm Taf Local Health Board ("the Health Board"). Mrs M was 86. She had a medical history which included atrial fibrillation ("AF"), Type 2 Diabetes, osteoarthritis and osteoporosis. She was taking a number of medications, including Warfarin (anticoagulation protection for AF). She was admitted to the Royal Glamorgan Hospital on 24 March 2012 because she was suffering with diarrhoea and vomiting.

Mr C said that at approximately 5.00pm on 4 April, while waiting to be discharged, Mrs M suffered a stroke. He said that despite family requests, his mother was not seen by a doctor for over six hours. Then, overnight whilst she was sleeping, she suffered a further significant stroke. Mr C said the Health Board repeatedly delayed responding to the complaint and he was dissatisfied with the way it handled the complaint and the complaint response.

My investigation considered the relevant records, comments from the Health Board and evidence provided by Mr C and his family. I took advice from an experienced physician, a Stroke specialist and an experienced senior nurse.

I upheld Mr C's complaint because I concluded that the care provided to Mrs M on, and leading up to, the evening of 4 April was inadequate. During her stay in hospital, by allowing the protection offered by anticoagulation to be inadequate, the Health Board failed to properly protect Mrs M from an avoidable stroke. The Health Board then failed to assess and treat her symptoms promptly and effectively. There was also a delay in her being seen by a suitably trained clinician and in transferring Mrs M to an Acute Stroke Unit.

My investigation also found that the Health Board failed to:

- follow the relevant NICE Stroke Guidance and did not have an adequate stroke protocol;
- provide (or record the provision of) appropriate nursing care;
- keep appropriate records;
- comply with Complaints Guidance.

The Health Board accepted the report and agreed to:

a) give Mr M an unequivocal written apology for the failures identified by this report;

b) give Mr C an unequivocal written apology for failing to comply with Complaint Guidance;

c) make a payment to Mr M of £5,500 to reflect the failings in care identified by this report; the uncertainty caused by those failings; the delays in the Health Board's handling of this complaint and the time and trouble taken by his family in pursuing the complaint with this office;

d) so that appropriate lessons may be learned, share this report with the medical, nursing, health care and administrative staff involved in the case;

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

- the failure of nursing staff to complete appropriate assessments and implement appropriate care plans
- the failure of staff to maintain appropriate records
- the failure of administrative, nursing and medical staff to follow the Complaints Guidance;

f) ensure compliance with current NICE guidance and professional guidelines, by reviewing (and if needed, updating) the current policies/protocols for the:

- management of in-patients on pre-existing Warfarin therapy
- INR monitoring of in-patients with relevant pre-existing conditions

(if needed, the Health Board should implement training for staff who indicate that they are not fully conversant with the relevant protocols);

g) ensure that staff training in respect of recognising acute stroke is up to date, with particular reference to the current NICE guidance and professional guidelines;

h) ensure that use of the NIHSS (or similarly recognised tool), in order to identify patients who are likely to have had an acute stroke, is implemented;

i) to ensure compliance with current NICE guidance and professional guidelines, review its arrangements for the identification and treatment of acute stroke and consider including the following measures:

- all patients who may have had an acute stroke should be immediately assessed by a suitably trained physician to determine whether thrombolysis is suitable
- all patients who may have had an acute stroke should have immediate CT scanning (i.e. within one hour)
- all patients who may have had an acute stroke should be assessed immediately for admission to a specialist acute stroke unit
- all patients who may have had an acute stroke should have a swallowing screening test (using a validated tool) by a trained professional within four hours;

j) give my office suitable evidence to demonstrate that it has complied with the recommendations.

Cardiff and Vale University Health Board and GP
Case references 201306223 and 201306224 - Report issued February 2015

Mrs H complained about the standard of care afforded to her late husband, X, by the Health Board's Mental Health Services and his GP practice, before his death in January 2013 (when he took his own life). X's clinical history included a number of incidents - he had self harmed, abused both alcohol and drugs and taken overdoses. In 2012, X continued to be treated by the GP Practice with increasing regularity, being prescribed a number of different medications to treat anxiety/mood disorders and/or depression. These included drugs known as benzodiazepines (known to be potentially addictive). X took an overdose of anti-depressants in January 2013, two weeks before his death, but was discharged from hospital and remained on a waiting list for counselling (which he had been on for some time). However, before he could be seen, X took his own life. Mrs H also complained that she had subsequently received a letter addressed to X inviting him for a counselling appointment at the Practice, which compounded her distress. An inquest touching upon X's death returned a verdict of suicide but noted "That there was a failure by those treating him to identify his suicidal intent."

Following advice from my clinical advisers, the complaint was mostly upheld. Whilst I could not conclude with any certainty that the outcome would have been different, were it not for the failings found during the investigation, failures on the part of both the Health Board and the Practice included the following:

- Lost opportunities on the part of the Health Board to properly evaluate X's mental health following earlier serious incidents and to comprehensively assess him when he was seen.
- A failure on the part of the Health Board to discuss X's discharge after an overdose two weeks before his death, and a failure to provide discharge information to the Practice in a timely way.
- Numerous errors in the Health Board's own investigation, following X's death, which indicated a lack of proper care and attention.
- A failure on the part of the Practice to refer to secondary care and/or a failure to properly assess X's suicide risk.
- The Practice's continued prescribing of benzodiazepines was contrary to national guidance.

I recommended that both the Health Board and the Practice apologise to Mrs H, and offer her redress of £1,500 each, for the failures identified, her distress, and her time in pursuing the complaint.

Further recommendations included the provision of evidence by the Health Board of its audit of discharge communication with GPs, its reminder to staff conducting investigations of serious incidents and reminders about comprehensive risk assessments. In relation to the Practice, further recommendations were made about continued auditing and monitoring of its benzodiazepine prescribing and that it should produce a Practice Prescribing Policy. Both the Health Board and the Practice accepted my recommendations in full.

Hywel Dda University Health Board and GP
Case references 201302382 & 201306002 - Report issued September 2014

Mrs X complained that her mother's GP had failed to ensure that aspirin, which had previously been prescribed for atrial fibrillation, was reinstated following a period when it had been stopped because she was taking warfarin. Mrs X said that her mother, Mrs Y, had suffered a debilitating stroke, which she believed could have been avoided, or its severity reduced, if she had been taking aspirin.

Although I found that the GP had failed to re-prescribe aspirin for Mrs Y in January 2013, there was no evidence that aspirin would have reduced the risk of Mrs Y suffering a stroke.

My advisers expressed concerns about the failure of the GP to consider prescribing warfarin, rather than aspirin, for atrial fibrillation, and the failure of secondary care professionals in the Health Board to alert the GP to consider this. The scope of my investigation was therefore broadened to include the Health Board.

I found that it had not been unreasonable for the GP to prescribe aspirin in 2004, as guidelines at that time did not clearly recommend warfarin. However, a CT scan in 2011 showed that Mrs Y had suffered a stroke; she was therefore known to be at high risk of a further stroke, and the Health Board ophthalmology service, which had arranged the scan, should have referred her to the Stroke Department. Also, the GP should have considered prescribing warfarin for her, in accordance with guidelines at that time.

Further opportunities to recognise the situation were missed in July and September 2012; in July Mrs Y suffered a DVT, and was prescribed a six month course of warfarin, but neither the clinician who referred her to the haematology department in July nor the cardiologist who saw her in September alerted the GP to the desirability of considering prescribing warfarin for Mrs Y on a longterm basis. The GP did not review Mrs Y's medication then or subsequently. I found that these were serious failings and upheld the complaint; if Mrs Y had been taking warfarin the risk of her suffering a stroke would have been significantly reduced, although he could not conclude that she would not have done so.

I recommended that the GP should:

a) apologise to Mrs X for the failings identified;

b) pay Mrs X the sum of £1,000 in recognition of the significant distress the failings had caused her;

c) if she had not already done so, carry out an audit of all patients at the Practice who have been diagnosed with atrial fibrillation, to ensure they are prescribed the most appropriate anticoagulant;

d) introduce and maintain a register of such patients, with annual review of their treatment being carried out.

I recommended that the Health Board should:

a) apologise to Mrs X for the failings identified;

b) pay Mrs X the sum of £1,000 in recognition of the significant distress the failings had caused her;

c) consider the introduction of a register and annual medication review of patients with atrial fibrillation;

d) introduce a procedure to ensure a medication review by the original clinician before the discharge of a patient on warfarin;

e) advise all clinicians to be explicit in their correspondence with GPs as to their expectations for future management of the patient;

f) undertake a review of the procedures in the ophthalmology department for referral to other specialties.

Aneurin Bevan University Health Board
Case reference 201302660 - Report issued July 2014

Mrs X complained about the length of time that her father (Mr Y) had to wait to be seen following a referral made by his GP in September 2012 for an endoscopy at the Royal Gwent Hospital. Mrs X highlighted that there had been a downgrading of the referral from urgent suspected cancer (USC) without her father having been seen and without any discussion with his GP. She was also concerned about the lack of clear ownership and responsibility for her father's care. Mrs X said that there was a lack of cohesion between the differing specialities involved which resulted in communication failures. Mrs X was of the view that her father's treatment and quality of life might have been improved if he had been seen in a more timely manner.

Mrs X also complained that the Health Board's subsequent investigation into her complaint failed to accept responsibility and acknowledge the harm that was caused by the delay in Mr Y receiving attention. In investigating the complaint the Acting Ombudsman took account of the view of one of her Clinical Advisers. The Acting Ombudsman found there to be unacceptable delays in the care provided and said that no sense of urgency was shown to Mr Y's clinical condition. She said that there were shortcomings in the leadership and ownership of the care and treatment being provided to Mr Y. The Acting Ombudsman raised concern about inadequate communication with the GP and with Mr Y and his family. The Acting Ombudsman highlighted that the relevant Health Board policy did not comply with the NICE guidelines. The Acting Ombudsman was also concerned about the waiting time for an urgent outpatient appointment. She said there had been an unnecessary delay in an endoscopy procedure being carried out. The primary site of cancer was identified following this.

The Acting Ombudsman upheld the concerns raised by Mrs X about the clinical care. She noted that although a more timely response would not have changed the sad outcome, it might have avoided the unnecessary psychological suffering felt by Mr Y and his family. It was also possible that a tracheostomy procedure could have been avoided.

The Acting Ombudsman also upheld Mrs X's complaint about the Health Board's subsequent complaint investigation.

The Acting Ombudsman recommended that the Health Board should:

a) provide an apology to Mrs X for the significant shortcomings in her father's care and treatment;

b) provide financial redress to Mrs X of £1,500 for the distress caused to Mr Y and his family and £500 for the time and trouble incurred in making a complaint and for the shortcomings in the complaint response;

c) review the endoscopy referral criteria for USC to ensure consistency with the relevant NICE guideline;

d) ensure that the First Consultant Gastroenterologist considered the issues raised in this case.

e) take action to ensure that the unacceptable delays for urgent outpatient appointments are addressed;

f) review the process to ensure that abnormal results are acted upon urgently by a lead clinician or relevant cancer MDT;

g) review how it communicates effectively and appropriately with patients and their families, particularly when more than one speciality is involved;

h) comply with the "Putting Things Right" framework including a proper consideration of "qualifying liability" and seeking independent clinical advice in appropriate circumstances.

Betsi Cadwaladr University Health Board
Case reference 201301339 – Report issued June 2014

Ms A complained that Betsi Cadwaladr University Health Board ("the Health Board") unreasonably delayed two of her appointments, at its Glaucoma Review Clinic (Glaucoma is a disease which damages the optic nerve and causes vision loss). She said that she needed emergency treatment as a result. She contended that she sustained significant vision loss in her right eye and experienced "considerable distress" because of these appointment delays. She indicated that she was dissatisfied with the Health Board's response to her complaint because it took too long to provide it and asserted that her sight was "unaffected" by these appointment delays.

The Acting Ombudsman upheld Ms A's complaint. She considered that the Health Board delayed Ms A's Clinic appointments unreasonably and failed to manage her glaucoma-related risks appropriately.

She was also of the view that it took too long to respond to Ms A's complaint and failed to update her and manage the issue of possible qualifying liability appropriately. She recommended that the Health Board should:

a) write to Ms A to apologise for the failings identified;

b) write to Ms A to explain how it determined that there was no qualifying liability in her case;

c) review its ophthalmology services with reference to her investigation report and a pre-existing "Situation Background Assessment Recommendation" ("SBAR") report; and,

d) prepare another SBAR report following this review.

The Acting Ombudsman also considered it appropriate to recommend financial redress for Ms A. However, she did not do so because Ms A did not want such redress. The Health Board agreed to comply with the recommendations made.

Cwm Taf Health Board
Case reference 201300374 – Report issued May 2014

Mrs C complained, through her solicitor, that the Health Board had failed to diagnose her brain tumour in a timely way; instead for over a year she was managed and treated for a stroke, and was later referred for a mental health assessment. Consequently, Mrs C said, she was not provided with earlier relief from the distressing symptoms she suffered and she was made to feel that her symptoms were psychosomatic. In addition, Mrs C complained about how the Health Board had dealt with her subsequent complaint.

The investigation found failings in Mrs C's clinical management. The Acting Ombudsman's Independent Clinical Advisers said that Mrs C's multiple admissions to hospital should have triggered consideration of an alternative diagnosis to a stroke much sooner. She ought to have been referred for an MRI scan and/or to a Neurologist. Two failed referrals could not be explained. The Consultant treating Mrs C for a stroke worked alone at the time; this was criticised as it gave no opportunity to discuss complex presentations. The referral requests to Radiology were found to be insufficient or illegible resulting in failed communication and misinterpretation of some images. This resulted in a 12 month period of additional distress for Mrs C albeit that, unfortunately, no surgical intervention could have been offered to her. There was some delay in the Health Board responding to requests made by Mrs C's solicitor as part of her complaint. Mrs C's complaints were upheld.

The Health Board agreed to all the Acting Ombudsman's recommendations:

a) to apologise and offer redress of £2,500 to Mrs C for her distress as a result of the failings and delays identified;

b) through a Clinical Lead, to issue reminders to all staff of the need to provide accurate, clear requests to Radiology colleagues and also to properly evidence inter-clinician referrals clearly in the clinical records;

c) Mrs C's case should be used as a learning exercise and discussed at a joint meeting of all departments involved; and,

d) the Radiology service should consider participating at an early stage in future Welsh trials of the electronic ordering of Radiology requests.

Abertawe Bro Morgannwg University Health Board
Case reference 201205048 – Report issued May 2014

Mrs A complained about the care provided for her late father, Mr B, by Abertawe Bro Morgannwg University Health Board ("the Health Board"), at Morriston Hospital ("the Hospital"). Her complaint concerned the diagnosis and investigation of his condition, his treatment in the Emergency Department, his discharge from the Hospital, his spinal surgery, his ophthalmology input, his manual handling assessment and his personal care. Mr B had cancer.

The Acting Ombudsman upheld Mrs A's complaint. She considered that the Health Board had not investigated Mr B's condition appropriately, diagnosed it correctly soon enough, provided timely triage for him, managed his discharge, pain and handling-related needs effectively or consistently given him a reasonable standard of personal care. She recommended that the Health Board should:

a) write to Mrs A to apologise for the failings identified;

b) pay Mrs A a nominal sum of £1,500 in recognition of the significant distress that its failings caused;

c) formally remind its clinicians of the importance of identifying and responding to Red Flags (clinical indicators of possible serious underlying conditions that require investigation);

d) satisfy itself that its triage arrangements should avert any delay akin to that experienced by Mr B;

e) review its pain policy to ensure that it complies with the relevant pain management guideline;

f) arrange and provide discharge-related training for its nursing staff members;

g) formally remind its nursing staff members that they must ensure that their patient handling complies with the relevant best practice guidance;

h) formally remind its nursing staff members that they must assess and review the personal care needs of their patients systematically and record the service provision associated with them consistently;

i) formally remind its nursing staff members that they must ensure that their catheter care complies with the relevant best practice guidance;

j) arrange and provide pain management training for its nursing staff members;

k) share her investigation report with all relevant staff members and discuss it in an appropriate forum.

The Health Board agreed to comply with these recommendations.

Cartrefi Cymunedol Gwynedd
Case reference 201304611 - Report issued August 2014

Mr K complained that Cartrefi Cymunedol Gwynedd ("CCG"), his housing association landlord, had unfairly refused his application to adapt his property to install a walk-in shower. He said that CCG had accepted that he had a need for the adaptation, as two occupational therapy assessments had indicated.

Mr K explained that CCG had refused the application mainly because he and Mrs K were underoccupying their home, as it was a three bedroom property. It had stated that many families were awaiting such homes. Mr K asserted that CCG's decision to refuse the application and then turn down his appeal, demonstrated that its policies were discriminatory against older and disabled people. In addition, he considered that the way CCG handled his appeal was incorrect.

Mr K said that he was being forced to move from a home he had lived in for 36 years against his will because he could not use the bathroom facilities satisfactorily.

I concluded that broadly CCG was operating reasonable policies, which were compliant with legislation and took account of the balance between a prudent use of its housing stock and the rights of tenants. However, I found that CCG needed to do more to provide evidence of the number and waiting times of families within its policy framework.

In Mr K's case, however, I found that CCG had been maladministrative in its handling of the application and appeal. I found that the initial decision to refuse the application had been taken without due consideration of Mr K's circumstances. The appeal decision then failed to identify that omission. I considered that Mr K had not had a fair hearing as a result of these failures. Mr K had suffered an injustice in that context.

I upheld Mr K's complaint. I recommended that CCG:

a) apologise to Mr K;

b) pay him £300;

c) offer Mr K a fresh and prompt re-determination of his application;

d) review its Adaptations Policy with regard to one aspect of its wording;

e) consider how it could incorporate the evidential basis regarding the need for family homes into the Adaptations Policy.

CCG accepted these recommendations.

Carmarthenshire County Council
Case Reference 201304738 - Report issued January 2015

Mr Y complained about delay by the Council in investigating his concerns about his four year old daughter's welfare, when in her mother's care.

His concerns were the family's living conditions, the frequent changes of address and allegations of drug taking. He considered that some of the remarks made by a social worker regarding drug taking and parenting were "inappropriate."

I found that the Council failed to carry out a home visit and missed a number of opportunities to investigate Mr Y's concerns about the family's circumstances, which included a number of risk factors. Instead it relied on information from the school, where his daughter was a new pupil. It also failed to investigate properly a referral made from an English County Council's Children's Social Services Team where the concerns were similar to those raised by Mr Y and where an "urgent welfare check" was requested. It was several months before the home was visited and this was only after a referral from the police following a drugs raid. An assessment of the child's needs was not carried out before the child left the Council's area to return to Mr Y's care.

I found that a comment relating to drug taking and parenting made by a social worker was not appropriate given the lack of investigation and assessment of Mr Y's daughter's circumstances. He also highlighted very poor complaint handling and found that Council staff were defensive and lacked objectivity in dealing with Mr Y's representations. The Council failed to deal with the complaint under the Children's Complaints procedures which it should have done, and missed an opportunity to investigate the service failings in respect of Mr Y's daughter.

The Council accepted my recommendations to:

a) apologise to Mr Y and make a payment of £1,000 for the uncertainty caused by the lack of assessment together with his "time and trouble" in making the complaint;

b) arrange an audit (to be carried out independently of the Council) of referrals to its Children's Services Teams to review the appropriateness and consistency of its responses;

c) provide training on the Framework for the Assessment of Children in Need and their Families for all staff who deal with referrals and assessments;

d) review its arrangements for dealing with social services complaints, to ensure its compliance with recent legislation and guidance;

e) provide training on complaint handling for those staff dealing with complaints regarding the provision of services for children.

Llansannan Community Council
Case Reference 201304436 - Report issued July 2014

Mr Z complained that he had been wrongly prevented from attending monthly meetings of the Llansannan Community Council ("the Council"). He further complained that before he was told he could no longer attend, the Council had stopped providing any translation facility for those meetings. The Council transacts its business in Welsh and Mr Z does not understand Welsh.

The investigation found that there had been maladministration in the manner in which the Council reached its decision to prevent Mr Z attending meetings. There were no minutes or any record of the appeal Panel meeting at which the decision was said to have been taken. I also considered there were no evidenced grounds for its decision given the statutory enshrined right of members of the public to attend meetings of elected councils so long as no disruption was caused at meetings (when attendees could be asked to leave or that right withdrawn). There was no evidence of any disruption when Mr Z had attended; the decision had been solely based on his conduct in daily life outside meetings. Whilst not condoning that conduct, there was no basis to prevent Mr Z from attending.

The Acting Ombudsman was satisfied that the Council could, as it had done, elect to transact its business in Welsh but she was not persuaded that it had demonstrated how it might ensure the non Welsh speaking public could engage in its democratic business (as noted by guidance issued by the Welsh Government). Furthermore, the Council's own adopted Welsh Language Scheme stated that it would treat both languages equally. It could not therefore objectively be doing so if it failed to make some provision for those attending meetings who did not understand Welsh. Otherwise those members of the electorate could not understand what was being discussed.

The Acting Ombudsman made the following recommendations to the Council:

a) to apologise to Mr Z for the maladministration resulting in the injustice to him of not being able to attend monthly meetings;

b) to review a number of its policies including its Standing Orders and Welsh Language Scheme to ensure greater clarity as to its position on translation at business meetings;

c) to ensure it recorded decisions taken pursuant to its policies and procedures.

Annex B

Public Body Complaints

Statistical Breakdown of Outcomes by Public Body Complaints Investigated

COUNTY/COUNTY BOROUGH COUNCILS

County/ County Borough Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Blaenau Gwent	6	4	10				1		1	**22**
Bridgend	2	9	19				1		1	**32**
Caerphilly	9	19	19				1	1		**49**
Cardiff	11	41	27		17		1		1	**98**
Carmarthenshire	5	23	17	2	7	1	1		2	**58**
Ceredigion	3	12	12	1	2		7	1		**38**
Conwy	8	8	13		1					**30**
Denbighshire	7	10	8		1		1	1		**28**
Flintshire	7	20	12		3		1			**43**
Gwynedd	7	9	12		3		1		1	**33**
Isle of Anglesey	4	14	13							**31**
Merthyr Tydfil	5	5	6				1			**17**
Monmouthshire	2	9	5				2		1	**19**
Neath Port Talbot	3	15	14		3		2			**37**
Newport	1	14	18		1					**34**
Pembrokeshire	5	14	13		3					**35**
Powys	4	20	22		3		1	1		**51**
Rhondda Cynon Taf	4	17	13		1					**35**
Swansea	9	20	28		1		1			**59**
Vale of Glamorgan	6	9	12		3		1			**31**
Torfaen	2	7	13		4					**26**
Wrexham	7	22	22	1	5		1	1		**59**
TOTAL	**117**	**321**	**328**	**4**	**58**	**1**	**24**	**5**	**7**	**865**

OTHER LOCAL AUTHORITY

School Appeal Panels	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Roath Park Primary School			1							**1**
Sketty Primary School			1							**1**
Millbrook Primary School			1							**1**
Tiryberth Primary School					1					**1**
Bassaleg School			1							**1**
Bryngwyn school			1							**1**
Caerleon Comprehensive School			1							**1**
Llanishen Fach Primary School			1							**1**
Monnow Primary School					1					**1**
Radyr Comprehensive School			1							**1**
Rhydypenau Primary School			2							**2**
St. Richard Gwyn RC High School			1							**1**
Llysfaen Primary School									1	**1**
St Woolos Primary School			1							**1**
Ysgol Treganna			1							**1**
Ysgol Mynnydd Isa			1							**1**
Ysgol Bryn Teg		1								**1**
Mount Stuart Primary School			1							**1**
Exclusion Appeal Panel - Willows High School			1							**1**
TOTAL		**1**	**16**		**2**				**1**	**20**

OTHER LOCAL AUTHORITY (CONTINUED)

National Park Authority	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Brecon Beacons	1	1	1		1					**4**
Pembrokeshire Coast	1	1								**2**
Snowdonia	1		1							**2**
TOTAL	**3**	**2**	**2**		**1**					**8**

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

COMMUNITY/TOWN COUNCILS

Community or Town Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abertillery & Llanhilleth Community	2		1				1			**4**
Aberystwyth Town	2									**2**
Argoed Community (Flintshire)		2								**2**
Caerwent Community		1								**1**
Cefn Community							1			**1**
Connah's Quay Town			1							**1**
Cynwyl Elfed Community							1			**1**
Dolgellau Town		1								**1**
Dyffryn Arth Community		1								**1**
Hanmer Community		1								**1**
Llanedi Community	1		1		1					**3**
Llangattock Community			1						1	**2**
Llangennith, Llanmadoc & Cheriton Community		2								**2**
Llannon Community	1									**1**
Llanover Community		1								**1**
Llansannan Community			2			1			1	**4**
Maesteg Town									1	**1**
Mawr Community	1									**1**
Nannerch Community			1							**1**
Neath Town		1								**1**
Pembrey & Burry Port Town	1									**1**
Pennard Community		1	3		1					**5**
Talgarth Town		1								**1**
Total	**8**	**12**	**10**		**2**	**1**	**3**		**3**	**39**

REGISTERED SOCIAL LANDLORDS

Registered Social Landlord (Housing Association)	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abbeyfield, Flint Society Ltd					1					**1**
Bro Myrddin Housing Association Ltd	1		1							**2**
Bron Afon Community Housing Ltd		10	2							**12**
Cadwyn Housing Association Ltd			1							**1**
Cardiff Community Housing Association Ltd		7	2							**9**
Cartrefi Conwy		5	2							**7**
Cartrefi Cymunedol Gwynedd	2	6	5		3	1				**17**
Charter Housing Association	1	4	2		1				1	**9**
Clwyd Alyn Housing Association Ltd	1		6		1					**8**
Coastal Housing Group Ltd	1	1			1					**3**
Cymdeithas Tai Cantref		1								**1**
Cymdeithas Tai Clwyd Cyf			2							**2**
Cymdeithas Tai Eryri		1	1							**2**
Cynon Taf Community Housing		1			3					**4**
Family Housing Association (Wales) Ltd		1	2		1					**4**
Grwp Cynefin		2								**2**
Grwp Gwalia Cyf Ltd	1	6	13		1					**21**
Hafod Housing Association	1	5								**6**
Linc-Cymru Housing Association		3	1							**4**

REGISTERED SOCIAL LANDLORDS (CONTINUED)

Registered Social Landlord (Housing Association)	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Melin Homes Ltd		7	1		1					**9**
Merthyr Tydfil Care and Repair	1									**1**
Merthyr Valleys Homes		1								**1**
Mid Wales Housing Association Ltd	1	1	3							**5**
Monmouthshire Housing Association	2	2	1							**5**
Newport City Homes	2	1	2		1					**6**
Newydd Housing Association	1		3		1					**5**
NPT Homes	1	11	2		4		1		1	**20**
Pembrokeshire Housing Association Ltd		1	1							**2**
RCT Homes		4	1							**5**
Rhondda Cynon Taf Care and Repair	1				1					**2**
Seren Group	1		1							**2**
Tai Calon		5					1			**6**
Tai Ceredigion Cyf	1	8	1				1			**11**
United Welsh Housing Association		3	1		1				1	**6**
Valleys To Coast Ltd		2	1							**3**
Wales and West Housing Association		6	5							**11**
TOTAL	**19**	**105**	**63**		**21**	**1**	**3**		**3**	**215**

LOCAL HEALTH BOARDS AND NHS TRUSTS

Local Health Board/ NHS Trust	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abertawe Bro Morgannwg	8	33	30		16	1	17	5		**110**
Aneurin Bevan	10	30	22		8	1	24	2	2	**99**
Betsi Cadwaladr	8	31	32		10	1	27	13	2	**124**
Cardiff and Vale	7	24	19		16	1	15	8	1	**91**
Cwm Taf	6	9	12		3	2	11	4	1	**48**
Hywel Dda	6	36	24		13	1	11	5	2	**98**
Powys Teaching		5	15	2	6		1	6		**35**
Public Health Wales		1	1							**2**
Welsh Ambulance Services	2	4	4				1	1		**12**
TOTAL	**47**	**173**	**159**	**2**	**72**	**7**	**107**	**44**	**8**	**619**

OTHER HEALTH BODIES

Other Health	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Dentist	3	6	7	1	1		3	3		**24**
GP	7	26	34		3	2	29	19	1	**121**
Pharmacist		1	2				1			**4**
TOTAL	**10**	**33**	**43**	**1**	**4**	**2**	**33**	**22**	**1**	**149**

Community Health Council	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
Abertawe Bro Morgannwg			1							**1**
Board of Community Health Councils in Wales					1					**1**
Cardiff and Vale of Glamorgan			1							**1**
Cwm Taf		1	1							**2**
TOTAL		**1**	**3**		**1**					**5**

WELSH GOVERNMENT AND WELSH GOVERNMENT SPONSORED BODIES

Welsh Government	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
CAFCASS Cymru	3	4	5							**12**
CSSIW			5							**5**
Healthcare Inspectorate Wales		1			1					**2**
North Wales Valuation Tribunal	1									**1**
Planning Inspectorate	1	3	9							**13**
Welsh Government	7	12	16	1	1		2			**39**
Welsh Health Specialised Services Committee		1								**1**
TOTAL	**12**	**21**	**35**	**1**	**2**		**2**			**73**
Welsh Government Sponsored Bodies										
Care Council for Wales	1									**1**
Natural Resources Wales	1	3	5							**9**
Residential Property Tribunal for Wales	1									**1**
TOTAL	**3**	**3**	**5**							**11**
OVERALL TOTAL	**15**	**24**	**40**	**1**	**2**		**2**			**84**

INDEPENDENT CARE PROVIDERS

Independent Care Providers	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	Public Interest Report Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
BUPA Care Homes (Partnerships) Ltd		1								**1**
Hawthorn Court Care Home	1									**1**
Ty Hafan		1								**1**
White House Residential Care Home			1							**1**
Talbot Court Care Home							1			**1**
TOTAL	**1**	**2**	**1**				**1**			**5**

OTHERS

Other	Out of Jurisdiction	Premature	'Other' cases closed after initial consideration	Discontinued	Quick Fix/ Voluntary Settlement	S16 Report - Upheld - in whole or in part	Other Report Upheld - in whole or in part	Other Report - Not Upheld	Withdrawn	Total Cases Closed
National Assembly for Wales Commission	1									**1**
ESTYN	1									**1**
Body out of jurisdiction	3									**3**
TOTAL	**5**									**5**

Annex C

Code of Conduct Complaints:

Statistical Breakdown of Outcomes by Local Authority

COUNTY/COUNTY BOROUGH COUNCILS

County/ County Borough Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Blaenau Gwent	1			1				**2**
Caerphilly	4	1						**5**
Cardiff	15		2		1		3	**21**
Carmarthenshire	15							**15**
Ceredigion	2		1					**3**
Conwy	1							**1**
Denbighshire	2							**2**
Flintshire	1	1						**2**
Gwynedd	6	1			2			**9**
Isle of Anglesey	2		3		1			**6**
Merthyr Tydfil	4							**4**
Monmouthshire	2		1					**3**
Neath Port Talbot	2	1						**3**
Newport City			1					**1**
Pembrokeshire	5	1						**6**
Powys	8	2						**10**
Rhondda Cynon Taf	7		1		2			**10**
Swansea	9	1						**10**
Vale of Glamorgan Council	7		1					**8**
Torfaen	7	2						**9**
Wrexham		1					1	**2**
Total	**100**	**11**	**10**	**1**	**6**		**4**	**132**

COMMUNITY/ TOWN COUNCILS

Community or Town Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Abertillery & Llanhilleth Community	4		1					**5**
Aberystwyth Town	4		1					**5**
Ammanford Town	1							**1**
Arthog Community		1						**1**
Bangor City	1							**1**
Bethesda Community	1							**1**
Bridgend Town	3							**3**
Buckley Town	4							**4**
Caerwent Community	3							**3**
Caldicot Town	1							**1**
Coedpoeth Community	1						1	**2**
Connah's Quay Town	2							**2**
Dinas Powys Community	2							**2**
Fishguard & Goodwick Town				1				**1**
Holyhead Town	1							**1**
Kidwelly Town	1							**1**
Llanarmon yn Ial Community	1							**1**
Llanbadrig Community	1			2				**3**
Llanddulas and Rhyd y Foel Community	1	2			1			**4**
Llandeilo Town				1				**1**
Llandudno Town	2							**2**
Llanedi Community	1							**1**
Llanelli Rural	5							**5**
Llanfihangel ar Arth Community						1		**1**

COMMUNITY/ TOWN COUNCILS (CONTINUED)

Community or Town Council	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Llangattock Vibon Avel Community			1					**1**
Llangelynnin Community	1							**1**
Llangennith, Llanmadoc & Cheriton Community	8							**8**
Llanharan Community	1							**1**
Llanover Community Council	1							**1**
Llansanffraid Glan Conwy Community							1	**1**
Llansannan Community	2							**2**
Llansantffraed Community				1				**1**
Llansteffan & Llanybri Community	1							**1**
Llantwit Major Town	1							**1**
Llanwnda Community							1	**1**
Llay Community	3							**3**
Mumbles Community	3							**3**
Ogmore Valley Community		1						**1**
Penmaenmawr Town		3	1					**4**
Pennard Community	7							**7**
Prestatyn Town	1							**1**
Rhyl Town		1						**1**
Sully Community	1							**1**
Templeton Community				1				**1**
Tywyn Town	7		2	1	1			**11**
Y Felinheli Community	1							**1**
TOTAL	**78**	**8**	**6**	**7**	**2**	**1**	**3**	**105**

FIRE & RESCUE AUTHORITIES

Fire & Rescue Authority	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total Cases Closed
Mid and West Wales		1	1					**2**

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