Finance Committee

Meeting Venue:
Committee Room 2 - Senedd

Meeting date:
25 March 2015

Meeting time:
09.00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda – Supplementary Documents
Consultation Responses for Public Services Ombudsman for Wales

Please note the documents below are in addition to those published in the main Agenda and Reports pack for this Meeting

8 Consideration of powers: Public Services Ombudsman for Wales: Key Issues (12:00-12:30) (Pages 1 - 306)

Y Pwyllgor Cyllid

Ystyried Pwerau: Ombwdsmon Gwasanaethau Cyhoeddus Cymru

Ymatebion i'r Ymgynghoriad
Mawrth 2015

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Finance Committee

Consideration of Powers: Public Services Ombudsman for Wales

Consultation Responses
March 2015

*Ar gael yn Gymraeg /Available in Welsh

Doc Ref	Sefydliad	Organisation
PSOW 01	Gwasanaeth Dyfarnu Cwynion y Sector Annibynnol (ISCAS)	Independent Sector Complaints Adjudication Service
PSOW 01a	Dogfen ffeithiau Cymdeithas Gofal Iechyd Annibynnol Cymru ar gyfer 2013-2014	Welsh Independent Healthcare Association Credentials 2013-2014
PSOW 01b	Pwyntiau gweithredu Gwasanaeth Dyfarnu Cwynion y Sector Annibynnol o 4 Chwefror 2015	Independent Sector Complaints Adjudication Service Action Points from 4 February 2015
PSOW 01c	Gwasanaeth Dyfarnu Cwynion y Sector Annibynnol, Pwynt Gweithredu	Independent Sector Complaints Adjudication Service Action Point
PSOW 01a	Gwybodaeth Ychwanegol	Additional Information
PSOW 02	Cyngor Tref Cei Connah	Connah's Quay Town Council
PSOW 03	Cyngor Cymuned Mochdre gyda Phenstrywaid	Mochdre with Penstrowed Community Council
PSOW 04	Comisiynydd Pobl Hŷn Cymru	Older People's Commissioner for Wales
PSOW 05	Cyngor Tref Abergele	Abergele Town Council
PSOW 06	Un Llais Cymru	One Voice Wales
PSOW 07*	Archwilydd Cyffredinol Cymru	Auditor General for Wales
PSOW 08	Cymdeithas Llywodraeth Leol Cymru	Welsh Local Government Association
PSOW 08a	Cymdeithas Llywodraeth Leol Cymru, Gwybodaeth Ychwanegol	Welsh Local Government Association Additional Information
PSOW 09	Dr Nick O'Brien	Dr Nick O'Brien
PSOW 10	Comisiynydd Plant Cymru	Children's Commissioner for Wales
PSOW 11*	Comisiynydd y Gymraeg	Welsh Language Commissioner *Only available in English*
PSOW 12	Cyngor Gweithredu Gwirfoddol Cymru	Wales Council for Voluntary Action
PSOW 13	Comisiwn y Gyfraith	Law Commission
PSOW 14	Cyngor ar Bopeth Cymru	Citizens Advice Cymru
PSOW 15	Cyngor Gofal Cymru	Care Council for Wales

PSOW 16	Nodyn Briffio Ombwdsmon Gogledd Iwerddon	Northern Ireland Ombudsman Briefing Note
PSOW 16b	Ombwdsmon Gogledd Iwerddon	Northern Ireland Ombudsman
PSOW 17	Cyngor Tref Penarth	Penarth Town Council
PSOW 18	Cyngor Tref Pontardawe	Pontaradawe Town Council
PSOW 19*	Arolygiaeth Gofal Iechyd Cymru	Healthcare Inspectorate Wales
PSOW 20	Cyngor Cymuned Marshfield	Marshfield Community Council
PSOW 21	Prifysgol Lerpwl	University of Liverpool
PSOW 22	Comisiwn Ffiniau a Democratiaeth Leol Cymru	Local Democracy and Boundary Commission for Wales
PSOW 23	Cyngor Bwrdeistref Sirol Wrecsam	Wrexham County Borough Council
PSOW 24	Conffederasiwn GIG Cymru	The Welsh NHS Confederation
PSOW 25	Fforwm Gofal Cymru	Care Forum Wales
PSOW 26	Cyngor Dinas Caerdydd	City of Cardiff Council
PSOW 27	Jennifer Brown	Jennifer Brown
PSOW 28	Cyngor Tref Yr Wyddgrug	Mold Town Council
PSOW 29	Cyngor Tref Treffynnon	Holywell Town Council
PSOW 30	Cyngor Bwrdeistref Sirol Conwy	Conwy County Borough Council
PSOW 31	Ymateb ar y cyd gan Awdurdod Parc Cenedlaethol Bannau Brycheiniog ac Awdurdod Parc Cenedlaethol Arfordir Penfro	Joint response of the Brecon Beacons and Pembrokeshire Coast National Park Authorities
PSOW 32	Pwyllgor Safonau a Moesau – Cyngor Dinas Caerdydd	Standards and Ethics Committee – City of Cardiff Council
PSOW 33	Prifysgol Sheffield	University of Sheffield
PSOW 34	Cyngor Sir Caerfyrddin	Carmarthenshire County Council
PSOW 35	Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	Cardiff and Vale University Health Board
PSOW 36	Pwyllgor Safonau Cyngor Bro Morgannwg	Vale of Glamorgan Council's Standards Committee
PSOW 37	Cyngor Sir Ynys Môn	Isle of Anglesey County Council
PSOW 38	Grŵp Cartrefi Cymunedol Cymru	Community Housing Cymru Group
PSOW 39*	Anne Carys Jones	Anne Carys Jones

National Assembly for Wales

Finance Committee

Consideration of Powers

Public Services Ombudsman (PSO) for Wales

January 2015

Submission from

ISCAS
INDEPENDENT HEALTHCARE SECTOR
COMPLAINTS ADJUDICATION SERVICE

Independent Sector Complaints Adjudication Service
1 King Street, London
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Tel: 020 3713 1746
Email: info@iscas.org.uk
www.iscas.org.uk

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1. Executive Summary

2. The Independent Sector Complaints Adjudication Service (ISCAS) has operated the well-established Complaints Code of Practice across the UK independent healthcare sector for over 13 years.

3. The ISCAS three-stage complaints process has been running effectively throughout the 13 years and has been periodically reviewed. ISCAS operates a three stage process which reinforces local resolution. The stages are: Stage 1, *Local* Resolution; Stage 2, O*rganisational/corporate* Level Resolution; Stage 3, Independent Adjudication. ISCAS manages Stage 3 on behalf of its membership.

4. ISCAS does not support the Ombudsman's proposal to extend his jurisdiction to include private healthcare services on the basis that a mechanism for independent review of independent sector complaints already exists at no cost to the taxpayer. ISCAS would request a full discussion of any proposed levy for independent sector providers to come under the Ombudsman's scheme and would highlight a quote in the Ombudsman's own submission that "*The suggestion of a levy would … be very challenging to put into practice"* [2.4(e).

5. Furthermore, ISCAS would welcome the opportunity to enter into an information sharing agreement with the Ombudsman to jointly address the type of complaint that crosses between the NHS and independent sector, as referred to by the Ombudsman in his submission [2.4 (b)].

6. ISCAS has an Operating Protocol with Health Inspectorate Wales (HIW) and the Care Quality Commission (CQC) in England. Since April 2014 ISCAS has shared the outcomes of adjudications with the CQC in the same way the Parliamentary and Health Service Ombudsman shares its information. HIW has indicated its desire for ISCAS to similarly share the outcomes of any adjudication cases relating to independent healthcare providers in Wales.

7. ISCAS is aware of the proposals from the Department of Health Review of the Regulation of Cosmetic Interventions that the Parliamentary and Health Services Ombudsman covers all independent healthcare complaints **in England.** Unfortunately ISCAS believes that this is likely to have a detrimental impact in terms of delivering a timely outcome and ensuring all **English** complainants can access independent review and submitted a representation to the UK Parliament Health Committee to put forward this view.

8. By way of context, the independent healthcare sector in Wales is small and represents a tiny proportion of total healthcare provision across Wales. ISCAS represents all the six acute general hospitals and the two large specialist cosmetic providers in Wales. (ISCAS is aware that the six mental health providers that are members of the Welsh Independent Healthcare Association [WIHA] are entirely NHS-funded, meaning that all their patients already have access to the Public Services Ombudsman.) There are two further independent mental health providers that are not members of WIHA: Mental Health UK and Pastoral Healthcare.

9. The latest WIHA Credentials document[1] shows that the number of complaints made in WIHA acute hospitals represented less than 0.1 percent of all attendances – the actual figure being 159 complaints received at Stage 1.

10. ISCAS notes that the Ombudsman has put forward £180k-£270k as the total costs per annum for his proposals (*"dependent on the policy choice re the levy"* [3.4]). ISCAS would question that accepting oral complaints would have no associated costs for the Ombudsman as detailed in his submission to the Committee on 21 January 2015. In addition, there would surely be an associated cost with the required legislation change to Schedule 3 of the PSOW (Wales) Act that has not been accounted for.

11. ISCAS would like to draw the Committee's attention to the predicament of private patients treated within the NHS who have no ability to complain to any external body about their treatment**.** The Public Services Ombudsman does not include these complainants and NHS Private Patient Units (PPU)/private beds are not members of ISCAS and therefore have no access to an independent complaints adjudication process.

[1] Download the WIHA 2013/2014 Credentials document.

12. Introduction

13. The Public Services Ombudsman (PSO) for Wales has asked that his powers be reviewed and has submitted proposals to the Finance Committee around five key areas of change. Of particular relevance to ISCAS is the Ombudsman's proposal to extend and reform his jurisdiction to cover independent healthcare and our submission focuses on this proposal.

14. The ISCAS Complaints Code sets out clear standards for member healthcare organisations to abide by and improve the experience of complainants ensuring that all unresolved complaints have access to independent adjudication. In view of the recommendation to steer all complaints to the Ombudsman in future, the Finance Committee is asked to consider the experience and service of ISCAS.

15. It is questionable that public funds should be used for the independent healthcare sector when there is the voluntary ISCAS Complaints Code (Code) in operation with costs met by the independent healthcare sector that already covers all the significant independent healthcare providers in Wales.

16. Background of ISCAS

17. For over 13 years, patients using the services of the independent healthcare sector have had the benefit of an effective complaints resolution procedure from organisations signed up to the ISCAS Code and the independent adjudication service.

18. The Code was established following the work of the Health Select Committee (in England) in 1999 and has been revised a number of times, most recently in May 2013. The Code will be reviewed again in the first half of 2015. Overall the Code has a clear customer focus and is supported by the Medical Defence Organisations.

19. How ISCAS works

20. ISCAS is a not for profit company limited by guarantee, set up as a member-owned co-operative with a Governance Board and Management Team. ISCAS operates the Code including the third stage of the complaints resolution:

    Stage 1 - Local resolution (hospital/clinic level)
    Stage 2 - Internal review (CEO/Board of Trustees)
    Stage 3 - Independent Adjudication

21. ISCAS membership[2] comprises of corporate members across the healthcare industry in all four countries of the United Kingdom. ISCAS members share knowledge, experience and understanding on the effective management of complaints. The Code means complainants can raise a complaint about any aspect of service provided within the healthcare facilities of an ISCAS member.

[2] Membership listings can be found at www.iscas.org.uk following links to the membership directory

22. The three stages are essential in managing complaints and achieving resolution for the vast majority without accessing the final adjudication stage. The second stage allows an organisation to review a complaint outcome at senior level and is one step removed from day to day management to ensure all options have been exhausted to resolve the complaint.

23. Below are examples from two different ISCAS members about the number of local complaints and the number escalating to Stage 3 Adjudication:

24. Corporate cosmetic surgery provider (UK wide):
    Total complaints for year 2012/2013

Number of complaints at Stage 1	1288
Number of complaints at stage 2	45
Number of complaints escalated and to stage 3	4

    Organisation information: turnover of £37.5m (July 2011)

25. Two large corporate providers of acute hospitals (UK wide):
    Total complaints for year 2012/2013

	Provider A	Provider B
Number of complaints at stage 1	1943	1604
Number of complaints at stage 2	111	35
Number of complaints escalated to stage 3	9	3

    Organisation information:
    Provider A - Turnover of £821.5m (September 2012) with 2,761 beds
    Provider B - Turnover of £739m (December 2012) with 1857 beds

26. In Wales, four of the six acute general hospitals and the two large specialist cosmetic providers are all part of a wider corporate structure, with their head offices registered and operating out of England. For these providers Stage 2 Corporate Level complaints resolution currently happens at the corporate head offices.

27. Adjudication

28. The purpose and outcome of adjudication is principally to offer answers and then, if possible, to put things right in the most appropriate way.

29. The complainant benefits by not only being offered a deeper insight into the issues raised but may also receive a financial award in recognition of any failings. The Adjudicator reviews the case by reference to the documentary evidence of all correspondence and clinical records. The Adjudicator produces a comprehensive report of the case in the decision letter to the complainant.

30. Independent adjudication has a high success rate in resolving the more difficult or intractable complaints. The main aim of adjudication is to leave all the parties with a better understanding and insight into the issues that have been raised, which leads to a greater focus on the lessons learnt.

31. The outcomes include a wide range of remedies for example: a sincere apology, a goodwill payment and recommendations being made to the ISCAS member. Goodwill payments (with a maximum set at £5000) can be awarded by the Adjudicator and can help reduce litigation, and in fact become a viable alternative - especially for service complaints. Medical Defence Organisations acknowledge the benefits that this system has brought.

32. Further information about ISCAS can be found in the Annual Report at www.iscas.org.uk

33. **Extending the Ombudsman's jurisdiction to include private health services**

34. ISCAS does not support this proposal on the basis that a mechanism for independent review of complaints already exists at no cost to the taxpayer. Furthermore, ISCAS would welcome the opportunity to enter into an information sharing agreement with the PSO for complaints that cross between the NHS and independent sector.

35. ISCAS and adjudication costs:

36. Importantly, for complainants, there is no cost to them through participation and, therefore, no risk involved. Additionally, the decision to engage in the adjudication process does not preclude the complainant from pursuing litigation at a later stage.

37. ISCAS members pay an annual subscription to cover the management resource. This base cost is shared across all members on a sliding scale according to company size.

38. An individual ISCAS member meets the costs of the Adjudicator's case fee, any goodwill payment awarded and any associated clinical expert witness costs. In 2014, ISCAS Adjudicators reported on 40 complaints from across the UK. The average cost of an ISCAS Stage 3 Adjudication in 2014 was £2,430.

	2014
Ex Gratia Awards	£16,300
Adjudication	£64,115
Clinical Expert	£16,096

39. Compliance built into the ISCAS system:

40. Compliance with the ISCAS Code and the Stage 3 Independent Adjudication scheme is a criterion of membership of ISCAS.

41. When producing the Stage 3 Independent Adjudication report, the adjudicator also writes personally to the Chief Executive Officer of the ISCAS member to highlight any recommendations to practice and to require a report back to ISCAS to monitor compliance with the Code. The ISCAS Management Team also undertakes regular compliance checks on members.

42. The ISCAS Governance Board ensures the overall effective implementation of the Code of Practice. The Board has an independent Chair, Baroness Fiona Hodgson CBE, as well

as representation from the Patients Association, the Action against Medical Accidents (AvMA), a patient representative and ISCAS member representation. Outcomes and themes of adjudications are reported, as well as ISCAS activity and member compliance.

43. ISCAS has an Operating Protocol with Health Inspectorate Wales (HIW) and the Care Quality Commission (CQC) in England. Since April 2014 ISCAS has shared the outcomes of adjudications with the CQC in the same way the Parliamentary and Health Service Ombudsman shares its information. HIW has indicated its desire for ISCAS to similarly share the outcomes of any adjudication cases relating to independent healthcare providers in Wales. Furthermore, ISCAS is working with the Regulation and Quality Improvement Authority in Northern Ireland and Healthcare Improvement Scotland on a similar approach. The Operating Protocol also means that complainants are signposted to ISCAS.

44. For information, the ISCAS Director, Sally Taber, is a board member on the newly formed HIW Advisory Board.

45. ISCAS membership covers 98% of the acute hospital sector and other independent healthcare providers across the United Kingdom. However there remain a proportion of smaller independent healthcare providers that have not yet subscribed to ISCAS in the independent sector. If Healthcare Inspectorate Wales had the authority to require organisations to participate in an independent complaint review stage this would change the complaints experience for a complainant significantly and ensure all independent sector providers subscribed to ISCAS or an equivalent process. Indeed, ISCAS is seeing a movement towards this in England, where the CQC has started asking new registrants exactly this question.

46. The Ombudsman and NHS Private Patient Units/private beds

47. ISCAS has a particular concern about private patients using services within an NHS Trust such as Private Patient Units (PPUs)/private beds. In these services patients have no access to an independent review as the Ombudsman does not include these complainants and NHS-run PPUs cannot subscribe to ISCAS. ISCAS has escalated this issue a number of times to the Department of Health (England). Last year Baroness Fiona Hodgson CBE, Chair of the ISCAS Governance Board, raised the issue with the Secretary of State for Health Jeremy Hunt MP. Dr Dan Poulter MP replied on behalf of Jeremy Hunt and ISCAS continues to raise the issue of NHS-run PPUs not offering any independent review stage for complainants as there has been no change in this position to afford a better experience for those complainants.

48. The Ombudsman's proposals around four further areas of change

49. **Own-initiative investigation powers** – ISCAS is broadly supportive of this proposal in line with developments in complaints management across the UK. However, ISCAS agrees that *"it would be important to frame any changes in such a way as to ensure that the power would be used only where appropriate and cases could be referred to regulators or commissioners where this was a more suitable alternative"* [Ombudsman submission to the Finance Committee, 21 January 2015].

50. **Oral complaints** – again ISCAS supports this proposal and agrees that requiring complainants to submit evidence in writing is a barrier to the service and is out of touch with the electronic age. The ISCAS Code requires that members have a policy on complaints that are made by email, text or on social media. This is particularly relevant in the area of cosmetic surgery where the typical patient is young and tends to make use of social media to complain about services.

51. ISCAS is currently reviewing its Code of Practice and will be reviewing the Stage 3 Adjudication requirement for "*complainants to clarify* [their complaint] *in writing*" and its current practice is already to accept complaints via email through the ISCAS website or following a telephone call with a member of the Management Team.

52. Patient confidentiality, data protection and good information governance practices are important considerations when dealing with oral and electronic complaints.

53. ISCAS would question the Ombudsman's submission that accepting oral submissions would have no associated costs [Ombudsman submission to the Finance Committee, 3.2]. ISCAS believes that there would surely be an associated staff and time cost. Accepting telephonic complaints would require skilled staff to capture the complaint correctly, particularly as complaints referred to the Ombudsman tend to be of a complex nature. Furthermore, opening up the option of oral complaints will increase the number of complaints being self-referred to the Ombudsman.

54. **Complaints handling across public services** – while this proposal is not directly relevant to independent healthcare, ISCAS considers this to be an excellent proposal. ISCAS operates in a similar manner for ISCAS members by producing model complaints policies for members; sharing learning and best practice with members through a quarterly e-Newsletter; and hosting annual training seminars for members on complaints handling and learning from complaints. Data from the soon-to-be-published 2014 ISCAS Annual Report shows that complaints handling remains a key area of complaints against healthcare services.

55. **Links with the courts** – ISCAS supports the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review. ISCAS already offers such an option for complainants in the independent sector.

56. Under the ISCAS Code, ISCAS reminds complainants of their right to seek independent legal advice where any aspects of their claim might give rise to a clinical negligence claim. Even if independent legal advice is being sought about clinical negligence or might be sought in the future pending the outcome of the adjudication process, the Code recommends that the complaint can be considered under the complaints procedure and ultimately Stage 3 Adjudication.

57. The outcomes of Stage 3 Adjudication include a wide range of remedies for example: a sincere apology, a goodwill payment and recommendations being made to the ISCAS member. Goodwill payments (with a maximum set at £5000) can be awarded by the Adjudicator and can help reduce litigation, and in fact becomes a viable alternative - especially for service complaints. Medical Defence Organisations acknowledge the benefits that this system has brought.

58. ISCAS notes the Ombudsman's point at 2.5(a) that the *"bar should be set aside entirely, so that complainants can choose which is the more appropriate route for them."* It would seem that it is proposed that complainants would be forced to choose one particular route when ISCAS Adjudication allows complainants to pursue both avenues if they so choose. In addition, ISCAS would question whether all complainants are able to make an informed choice about which route is most appropriate for them, particularly vulnerable complainants.

59. Conclusion

60. In conclusion, ISCAS does not support the Ombudsman's proposal to extend his jurisdiction to include private healthcare services in Wales on the basis that a mechanism for an independent review of independent sector complaints already exists at no cost to the taxpayer and no requirement for legislative change.

61. ISCAS would welcome the opportunity to enter into an information sharing agreement with the PSO for any complaints that cross between the NHS and independent sector.

62. ISCAS is working closely with Healthcare Inspectorate Wales to formalise the process of sharing the outcomes of ISCAS adjudication cases in the same way that it already does with the Care Quality Commission.

63. If Healthcare Inspectorate Wales had the authority to require that independent healthcare providers participate in an independent complaint review stage, this would ensure that all providers would subscribe to ISCAS or an equivalent process. As detailed above, ISCAS has already noted the Care Quality Commission requiring this of independent sector providers in England.

Appendix I

Complaints Code of Practice

May 2013

Independent Sector Complaints Adjudication Service
1 King Street
London EC2V 8AU

Tel: 020 3713 1746

Website: www.iscas.org.uk

About this Code

Independent healthcare organisations (hospitals, clinics and doctors working privately) want to give all patients an excellent service. However, there may be times when they get it wrong. When this happens, they want to respond to complaints swiftly and, where they can, try to put things right.

This Code sets out the necessary standards that all independent healthcare organisations which are members of the Independent Sector Complaints Adjudication Service (ISCAS), have agreed to meet when handling complaints about their services.

This document describes the minimum standards for complaints handling. It also includes an explanation of adjudication arrangements, an independent way of resolving disputes with those independent hospitals and clinics that are members of ISCAS.[3] The costs associated with adjudication are met by the organisation and not by the complainant.

This Code applies to patients treated privately in an ISCAS member hospital or clinic, whether or not they paid for their care directly or through an insurance scheme. Complaints from NHS funded patients treated in an ISCAS member hospital or clinic should be handled according to the NHS Complaints Procedure. Sometimes this may mean ISCAS members handling complaints from NHS patients under this Code as part of the investigation under the NHS procedures (this does not include private patients in NHS Trusts).

The Code applies to complaints about doctors and other healthcare professionals working within member hospitals and clinics, even where they are not employed by the clinic and have practising privileges (this means they agree to provide certain services within the hospital or clinic as independent practitioners).

The Care Quality Commission (CQC) in England is the regulator for health and adult social care including independent healthcare services. It does not handle complaints[4], nor does it provide an arbitration service. However, it collects information about how independent healthcare services meet the regulations and standards it sets, and will take action where any offences have been committed. The Healthcare Inspectorate Wales (HIW), Health Improvement Scotland (HIS) and the Regulation and Quality Improvement Authority (RQIA) (Northern Ireland) regulate independent healthcare services in their respective countries. The regulators of each country recognise and signpost complainants to ISCAS.

[3] A full list of healthcare organisations that are members of ISCAS is available at www.iscas.org.uk

[4] The only exceptions to this are complaints from people whose rights are restricted under the Mental Health Act, or their representatives, about the way staff have used their powers under the Act.

Learning from complaints

Underpinning this Code is a commitment to value complaints for the feedback they provide about independent healthcare services, and to bring about quality improvements. In addition to acknowledging mistakes and apologising where it is appropriate, ISCAS members will inform a complainant about how the complaint was investigated, the lessons learned from their complaint and the actions they have taken as a result. This might include changing guidance to staff, or a policy, or it might mean providing new or different services.

Sometimes finding a remedy for a complaint requires more than this. ISCAS members will consider a range of remedies, which may include a goodwill payment in recognition of any shortfall in complaint handling, inconvenience, distress, or any combination of these. This Code also provides for the Independent Adjudicator (the final stage of the complaints handling process) to review a goodwill payment to the complainant.

The Independent Adjudicator (the final stage of the complaints handling process) can review or award a goodwill payment of up to £5,000. This is not designed to be compensation. If a complaint potentially appears to have arisen as a result of clinical negligence and compensation is sought, and/or might be awarded if a clinical negligence claim is successfully pursued, it may be appropriate to seek legal advice.

Principles

This Code reflects the *Principles of Good Complaint Handling* identified by The Parliamentary and Health Service Ombudsman. Good complaint handling means:

1. **Getting it right**
   Quickly acknowledging and putting right cases of maladministration or poor service that led to injustice or hardship. Considering all the factors when deciding the remedy with fairness for the complainant and where appropriate others who also suffered
2. **Being customer focused**
   Apologising and explaining, managing expectations, dealing with people professionally and sensitively and remedies that take into account individual circumstances
3. **Being open and accountable**
   Clear about how decisions are made, proper accountability, delegation and keeping clear records
4. **Acting fairly and proportionately**
   Fair and proportionate remedies, without bias and discrimination
5. **Putting things right**
   Consider all forms of remedy such as apology, explanation, remedial action or financial offer

6. **Seeking continuous improvement**
   Using lessons learned to avoid repeating poor service and recording outcomes to improve services.

ISCAS members are not public bodies, and ISCAS does not provide a public service[5]. However, these principles can be reasonably applied to independent healthcare hospitals and clinics. Therefore, ISCAS members are expected to have complaints handling procedures that are proportionate and reflect these principles.

Further details of these principles can be found at www.iscas.org.uk

The standards

The Code sets out a three stage process for handling complaints. All complaints should be raised directly with the hospital or clinic in the first instance (stage 1). Complaints should normally be made as soon as possible and within 6 months of the date of the event complained about, or as soon as the matter first came to the attention of the complainant. The time limit can sometimes be extended (so long as it is still possible to investigate the complaint). An extension might be possible, such as in situations where it would have been difficult to have complained earlier, for example, when someone was grieving or undergoing trauma.

In the event that the complainant is unhappy with the response to their complaint, they can escalate their complaint by asking the hospital or clinic to conduct a review of its handling (stage 2). Finally, if the complainant remains dissatisfied they can request independent external adjudication of their complaint (stage 3).

Stage 1: Local Resolution

ISCAS members will:

1. Have a written procedure on the handling of complaints. This should be concise, easy to understand and only contain relevant information about complaints handling. The procedure should be kept up-to-date and as a minimum include information about:
   - The process for handling complaints, including clinical governance arrangements within the hospital or clinic for investigating complaints, including where a clinical negligence matter may have arisen
   - The steps the ISCAS member will take to investigate the complaint which are thorough yet proportionate[6]
   - The timeframes the ISCAS member will work to in trying to resolve the complaint (see standards 9 and 10)
   - How complaints can be made, including how complaints submitted by email or text or using other media will be handled.

[5] The Court of Administration confirmed that ISCAS provides a private service and not a public service, as a result of an application for a Judicial Review of ISCAS in 2011.
[6] CQC: Essential standards of quality and safety, outcome 17

2. Ensure that the procedure on complaints handling is well-publicised and easily available to complainants. For example, ISCAS member websites should include information on 'how to complain' and confirm their membership of ISCAS. Complainants should be provided with a copy of the complaints procedure when they first raise concerns about any aspect of the service they have received.

3. Ensure that the ways in which complaints are accepted does not deter or disadvantage patients or their relatives from making complaints[7]. Reasonable assistance should be available to anyone needing help to make a complaint (for example, whose first language is not English or who may have a disability).

4. Offer complainants a face to face meeting to talk through their concerns and try to resolve the complaint early on.

5. Remind complainants of their right to seek independent or legal advice where any aspect of their complaint might give rise to a clinical negligence claim. Even if independent advice is being sought about possible clinical negligence the ISCAS Code recommends that the complaints procedure and ultimately stage 3 adjudication is continued.

6. Agree with clinicians who hold practising privileges that co-operation with the complaints procedure is a condition of working within the hospital or clinic, described in the Independent Healthcare Advisory Services (IHAS) Practising Privileges Model Policy.

7. Keep confidential all details relating to the complaint and its investigation, and seek appropriate consent from the complainant (or someone acting as their proxy) in circumstances where the investigation of their complaint requires the release of their medical records or sharing their information with other relevant parties.

8. Respond in writing to written complaints, whether made by letter, email or text. Any face to face or telephone discussions with a patient about concerns with the service they have received should be recorded in writing and normally be followed up in writing to the complainant.

9. Provide a written acknowledgement to complainants within 2 working days of receipt of their complaint (unless a full reply can be sent within 5 days).

10. Provide a full response to the complaint within 20 working days or, where the investigation is still in progress, send a letter explaining the reason for the delay to the complainant, at a minimum, every 20 working days.

[7] A communication constitutes a complaint when the issue requires investigation and a formal response.

11. Consider a wide range of appropriate and proportionate responses, including:

- Acknowledging when things have gone wrong
- Giving the complainant an apology, where appropriate
- Taking action to put things right
- Sharing details of how the organisation has investigated and has learnt from the complaint including any changes made as a result
- Making a gesture of goodwill offer, where appropriate.

12. Signpost complainants to the next stage of the complaints procedure, in the event that they are dissatisfied with the response to their complaint. This means an explanation to the complainant of the option to proceed to the stage 2 review of their complaint and what that entails. Complainants should also be informed that, should they wish to escalate their complaint to stage 2, they must do so in writing, within 6 months of the final response to their complaint at stage 1.

Stage 2: Complaint Review

ISCAS members will

13. Have arrangements in place by which to conduct a review of the complaint. Normally this will mean that a senior member of staff within the organisation, who has not been involved in handling the complaint at Stage 1 and is removed from the hospital or clinic that the complaint is about, will review all of the documentation and may interview staff involved, to form an independent view on the handling of the complaint.

14. In the case of smaller organisations there is a need to demonstrate processes that allow for an objective assessment of the complaint at stage 2.

15. Provide a written acknowledgement to complainants within 2 working days of receipt of their complaint at stage 2 (unless a full reply can be sent within 5 working days).

16. Provide a full response on the outcome of the review within 20 working days or, where the investigation is still in progress, send a letter explaining the reason for the delay to the complainant, at a minimum, every 20 working days.

17. Signpost complainants to the next stage of the complaints procedure, which means explaining their right to an independent external adjudication of their complaint, and the timescales for doing this. Requests for independent external adjudication should be made to ISCAS, in writing, within 6 months of receipt of the stage 2 decision letter. Requests for independent external adjudication will be allowed outside this timeframe only in exceptional circumstances.

Stage 3: Independent External Adjudication

ISCAS will

18. Have a written document that explains the Independent External Adjudication Process. This should be concise, easy to understand, and kept up-to-date. This document should be available on the ISCAS website and a hard copy sent to complainants on request.

19. Provide a written acknowledgement to complainants of their request for independent external adjudication within 2 working days of receipt of the request.

20. Check with the ISCAS member hospital or clinic that the processes for local resolution and stage 2 review have already been exhausted and obtain a response within 2 working days.

21. Refer complainants to the ISCAS member that their complaint is about, where the complaint has not been through local resolution stages 1 and 2.

22. Ask complainants to clarify in writing which aspects of their complaint they wish to refer for adjudication and consent to the ISCAS process and release of relevant case records from the ISCAS member.

23. Assign an Independent Adjudicator to consider the complaint. The adjudicator will be entirely independent of the ISCAS member organisation, and will have the necessary skills and experience to perform this role.

24. Ensure that complainants understand the binding nature of the independent external adjudication. In order for a complaint to proceed to Independent External Adjudication, the complainant must accept:

- The finality of the decision by the Independent External Adjudicator;
- That any decision and/or goodwill payment awarded by the Independent External Adjudicator brings the complaint process to a close;
- That the Independent Adjudicator's decision is binding on the ISCAS member. However, for the avoidance of any doubt (subject to paragraph 24 below), any award of a goodwill payment recommended by the adjudicator does not preclude a complainant from seeking any additional legal remedy; monetary or otherwise.

25. Remind complainants of their right to seek independent legal advice where any aspects of their complaint might give rise to a clinical negligence claim. Even if independent legal advice is being sought about clinical negligence or might be sought in the future pending the outcome of the adjudication process the ISCAS Code recommends that the complaint can be considered under the complaints procedure and ultimately stage 3 adjudication.

The Independent Adjudicator will

26. Accept complaints for adjudication, unless:

- It is reasonable to consider that the complaint has been resolved, or
- The ISCAS member has genuine and reasonable grounds for considering that the complaint can be resolved locally and takes active steps to achieve this, or
- The complaint is outside the remit of the Code for complaints handling, or
- It is reasonable to consider that the complaint is vexatious, or
- In exceptional circumstances a reasonable and acceptable request has been made by the ISCAS member hospital or clinic that the case should be deemed closed at stage 2 and not proceed to stage 3.

27. Provide a written acknowledgement to complainants within 2 working days of receiving from ISCAS, documentation relating to their complaint.

28. Provide a full adjudication decision within 20 working days or send a letter explaining the reason for the delay to the complainant, at a minimum, every 20 working days.

29. Consider a wide range of remedies, including asking the ISCAS member:

- to provide an explanation and apology, where appropriate
- to take action to put things right
- to share details of how the organisation has learnt from the complaint and any changes made as a result
- to offer a goodwill payment in recognition of shortfalls in the complaint handling, inconvenience, distress, or any combination of these, up to a limit of £5,000. Any goodwill payment awarded by the Independent External Adjudicator should take account of any claim that the ISCAS member has against the complainant (e.g. for unpaid hospital fees). Acceptance of the goodwill payment by the complainant will bring all matters that are subject to the complaint to a close.

30. Consider using appropriate resources to assist the adjudicator in his/her determination. Such resources may include the commissioning of clinical and technical reports from external experts[8], and or requests for further documentation or clarification from the complainant or the ISCAS member. In some cases, the Adjudicator may need to speak with the complainant or the ISCAS member, in order to decide how best to resolve the complaint.

[8] ISCAS uses experts from a reputable and recognised source ensuring there is no conflict of interest

Breaches of the Code

ISCAS members will

31. Undertake an annual self assessment of compliance against the standards set out in the Code. They are required to declare the outcome of this assessment to ISCAS, together with an action plan that sets out how they will meet standards with which they have not been compliant.

32. Cooperate with ISCAS to address areas of non-compliance.

ISCAS will

33. Publish an annual report on how ISCAS members are performing against the standards set out in the Code. This will be based on the self-assessments conducted by ISCAS members, themes arising from Independent External Adjudication and other ISCAS activity in the reporting year.

34. Undertake a performance assessment of ISCAS members that repeatedly fail to meet the Code's standards.

35. Take steps to remove the membership of any ISCAS member that persistently fails to meet the Code's standards and does not engage with ISCAS to improve its complaints handling.

Complaints about ISCAS or the Independent Adjudicator

Complaints about the way ISCAS has handled a complaint at stage 3, or about the Independent Adjudicator, should be made in writing to the Director, ISCAS. A complaint can only be made if the complainant believes that ISCAS and or the Adjudicator have failed to carry out the process of adjudication properly.

THE ISCAS DIRECTOR will

I. Acknowledge receipt of the complaint within 2 working days.

II. Invite the complainant to meet to help resolve the complaint, where this may be helpful.

III. Investigate and respond to the complaint in full within 20 working days.

IV. Refer the complaint to the independent Chair of the ISCAS Governance Board if the complaint cannot be resolved after 20 days and notify the complainant accordingly. The Chair will consider the complaint about ISCAS and may hold a small panel to consider a case. A response will be made within 20 working days.

V. Report all complaints about ISCAS to the Governance Board and publish information about feedback from those who use the service.

Dealing with abusive or vexatious complaints

ISCAS members should have a policy in place to handle situations where people pursue their complaint in a way that can impede its investigation, can cause significant resource issues for the organisation, or which involves unacceptable behaviour (such as leaving multiple voicemails or emails, or using abusive language). The policy should set out how the organisation will decide which complainants will be considered vexatious or unreasonably persistent, and how the organisation will respond in those circumstances.

ISCAS has its own policy for handling vexatious complaints and provides guidance to members on its application.

Welsh Independent Healthcare Association
Cymdeithas Gofal Iechyd Annibynnol Cymru

High quality patient care
Working in collaboration
Investment in local economy

2013/2014 CREDENTIALS DOCUMENT

Gofalu am Gleifion dros Gymru

Investment in the latest equipment is essential for the care of our patients

The Mental Health sector provided **85,000** patient bed days in 2013-2014

The acute sector provided over **16,500** in-patient/day case episodes in 2013-2014

The Learning Disability Services provided over **21,700** bed days in 2013-2014

WIHA members ensure their staff receive high quality training and development to ensure continuing high levels of care

Introduction

The past year has seen a number of changes in the independent sector, both in terms of acute provision and mental health regulation. Nevertheless, and despite the challenging economic climate, many thousands of patients have used the services and treatments provided by independent hospitals in Wales.

We employ almost 2,000 people and treat tens of thousands of patients every year, either as inpatients or on an outpatient basis, and across a range of general health services but increasingly in particular areas of more specialist care and treatment.

We are working more and more closely in an advisory and collaborative way with both the Welsh Government and Health Boards to improve alignment with our common objectives of the highest standards of patient safety and quality. We believe there is more scope to develop shared learning and ideas in healthcare innovation and improvement by working in a more collaborative manner.

As local employers often in areas with higher than average levels of unemployment, we also provide opportunities for employment across a range of disciplines and areas. We seek to promote good practice in our employment practices and by doing so to demonstrate our commitment to Corporate Social Responsibility.

The Welsh Independent Healthcare Association (WIHA) was formed several years ago and aims to provide a single co-ordinated voice to facilitate consultation and share practice across the sector, helping to streamline communication and avoid repetition and engagement with a multiplicity of individual organisations.

We have compiled this booklet to provide some key facts and figures about the independent healthcare sector in Wales. A detailed summary is available of the result of the audit.

I hope you find this booklet helpful and please do contact me if you would like more information about the WIHA, its members, or the work of the independent health sector in Wales.

Thank you.

Simon Rogers,
Chairman WIHA

Telephone: 01443 449292

Email: simon.rogers@nuffieldhealth.com

About the Independent Health Sector

The WIHA is made up of:

- 6 acute hospital organisations
- 6 mental health organisations (comprising 23 units)
- 2 organisations providing learning disability services

All of these hospitals collaborate with a wide range of stakeholders, including patients, consultants and their professional associations, regulatory bodies, intermediaries, Local Health Boards, GPs and community health services.

The six acute independent hospital organisations which took part in this audit:

- Treated more than 16,500 inpatient/day cases in the period 2013-14.
- Managed more than 23,000 bed days in the same period.

The six mental health organisations:

- Managed more than 85,000 bed days, again in the same period
- All of the NHS funded bed days.

The learning disability units:

- Managed over 21,700 bed days, in the same period
- All of them NHS funded beds.

All WIHA members have a commitment to quality assurance as a key part of the delivery of safe and effective services to patients, and they have systems in place to identify the central cause of any issues raised which help to ensure that problems do not recur.

In addition, the sector makes a sizeable contribution to both Welsh employment and the Welsh economy by providing employment for a large number of people, while the vast majority of the goods and services are bought locally.

These include areas such as foodstuffs, supplies, engineering support, grounds maintenance, building and construction.

Our patients rate the level of care they receive extremely highly


Total staff in sector
1,928
Acute inpatients discharges
16,901
Acute outpatient attendance
143,296

Ensuring the Quality of Clinical Care

Patients in the independent sector receive high standards of clinical care, and are treated in high-quality facilities by leading consultants using some of the latest technology.

WIHA members have stringent measures in place to combat Methicillin Resistant Staphylococcus Aureas (MRSA) and other hospital acquired infections.

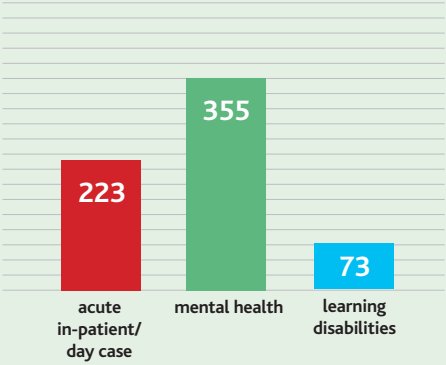
As a result, no incidences of hospital acquired MRSA Bacteraemia and only 1 case of Clostridium Difficile were recorded in the WIHA acute hospitals completing the questionnaire in 2013/2014, and they managed a total of 23,134 bed days.

99%

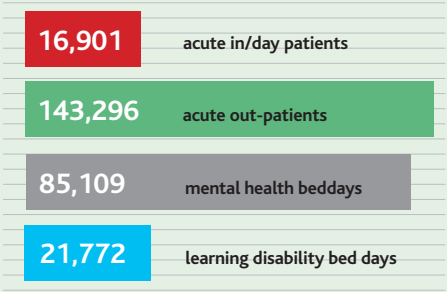
of patients would recommend our hospitals to others

Summary of results of the audit

number of beds



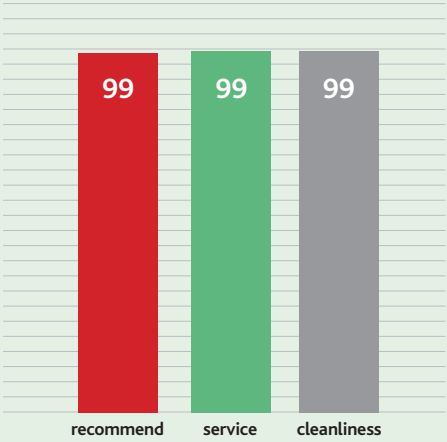
number of patients treated



levels of patient satisfaction and complaints

All the independent sector organisations in the audit have high rates of patient satisfaction. The average results in 2013/14 for the WIHA group were:

- **99%** of patients surveyed would recommend our hospitals to others
- **99%** of patients rated the service as either excellent, very good, or good.
- **99%** of patients rated the cleanliness of the facility as excellent, very good or good.



Quality assurance

The independent health sector receives very few complaints.

- In the mental health hospitals complaints represented just 0.04 per cent of patient days.
- The number of complaints made in the acute hospitals represented less than 0.1 per cent of attendances.

99% rated the cleanliness of our hospitals as excellent, very good or good

Complaints across the sector represented less that 0.1% of all patient activity

Organisations who are members of WIHA and supplied data for this document:

Acute Surgical:

- BMI Werndale Hospital, Carmarthen
- Nuffield Health Cardiff & Vale Hospitals, Cardiff and Vale of Glamorgan
- Sancta Maria Hospital, Swansea
- Spire Cardiff Hospital, Cardiff
- Spire Yale Hospital, Wrexham
- St Josephs Hospital, Newport

Mental Health:

- The Cambian Group
- Lighthouse Healthcare, Phoenix House
- Ludlow Street Healthcare
- Partnership in Care, Llanarth Court Hospital, Raglan
- Priory Group
- Rushcliffe Independent Hospital

Learning Disabilities:

- Ludlow Street Healthcare
- Priory Group

Organisations not participating are Mental Health UK and Pastoral Healthcare

Produced by Welsh Independent Healthcare Association with grateful thanks to Lene Gurney, Association of Independent Healthcare Organisations (AIHO)
Independent Healthcare Advisory Services (IHAS) Division (lene.gurney@aiho.org.uk).

Further information about the WIHA can be found at
www.independenthealthcare.org.uk/wiha

ISCAS
INDEPENDENT SECTOR
COMPLAINTS ADJUDICATION SERVICE

ANNUAL REPORT 2013

Adjudicating Complaints for the Independent Healthcare Sector

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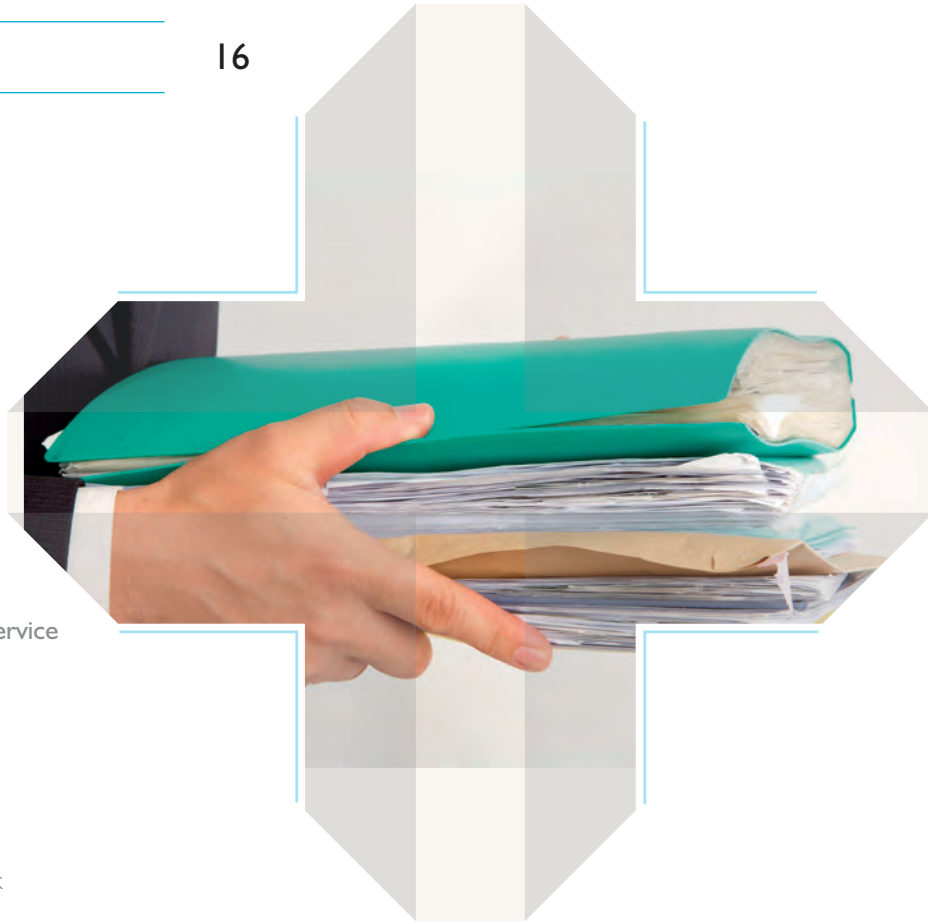

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Foreword

by Sally Taber, Director of ISCAS

This is the 13th year of the Independent Sector Complaints Adjudication Service, ISCAS, which we formed in response to a report by the Health Select Committee. Essentially derived from best practice of the members of the trade association serving independent acute hospitals, it added the element of external adjudication by an independent body, which enabled both complainants and providers to find closure of otherwise intractable complaints under a code of practice which is equitable and fair. Free to consumers, the adjudication process fosters a culture of learning, and assures the consumer that the complaint has a positive result.

The ISCAS Annual Report goes to subscribing members of ISCAS, government, professional and system regulators, the Parliamentary and Health Service Ombudsman and the general public via its website. It has been my endeavour to put best practice in handling complaints into the forefront of our subscribing member's minds, and to this end we have in 2013 revised and reformed the Code of Practice and expect our members to further develop their complaints management procedures to reflect these improvements.

During this year, a review of cosmetic interventions by Sir Bruce Keogh recommended that all private healthcare complaints in England should be handled by the Parliamentary and Health Service Ombudsman. The report adduced no evidence that ISCAS (to which over 90% of independent acute hospitals in England belong) was failing consumers. We believe that a public funded agency would be ill-suited to the independent healthcare sector, and have therefore put forward to government the successful ISCAS model as the foundation of a complaints management code to be mandated for the whole independent healthcare sector. This would be regulated by the Care Quality Commission in England, Healthcare Inspectorate Wales in Wales, Healthcare Improvement Scotland in Scotland and the Regulatory and Quality Improvement Authority (RQIA) in Northern Ireland.

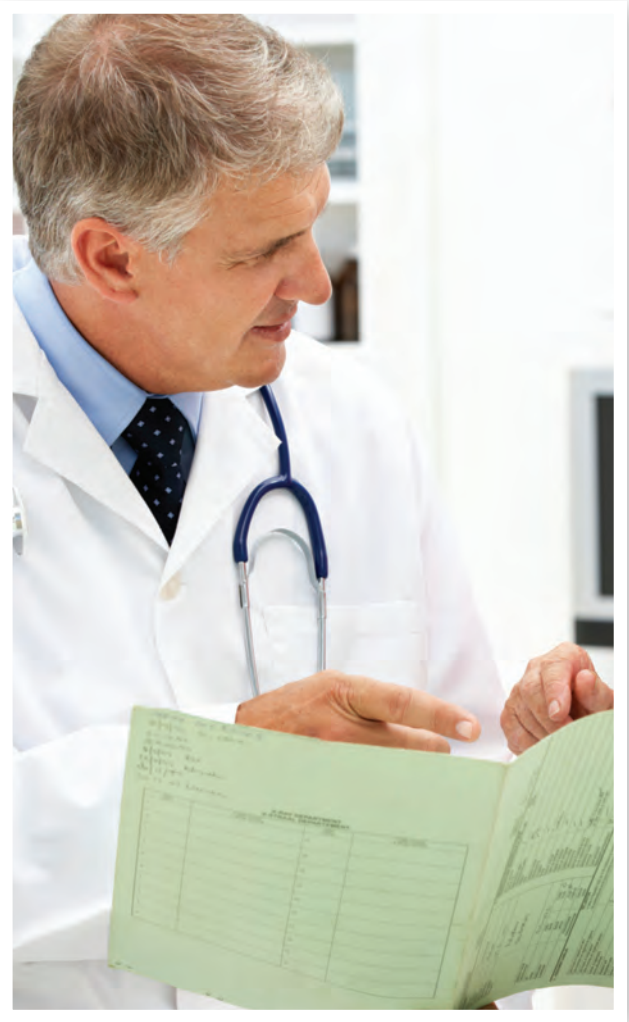
We do recognise that ISCAS serves only the healthcare providers already committed to high standards of consumer service. There are many healthcare providers who will have no recognised independent review process and this undoubtedly gives rise to difficulties. During recent years we have extended the reach of ISCAS in conjunction with the Independent Doctors Federation, whose fast growing membership encompasses doctors who are in independent practice. Patients of such doctors who need to complain now have a recognised route to resolution. In other cases we have invited new clinics to adopt the ISCAS Code – specifically the Private Ambulance Service and BCAM (British College of Aesthetic Medicine), thus extending its protection further to patients.

With our codes' recognition as suitable for the organisations they inspect, we believe that the CQC could do more to require other clinics to adopt the ISCAS Code, for the ultimate benefit of patients. Be it noted, ISCAS is not toothless, removing from membership more than one provider who has failed to abide by the Code; and reporting to the professional and system regulators instances of concern.

ISCAS is built upon the principle of openness, appropriately in this era of the increasingly well-informed patient.

Introduction

The Independent Sector Complaints Adjudication Service (ISCAS) operates the well-established, and recently revised, independent healthcare sector's Complaints Code of Practice (Code) and provides independent adjudication for complaints made against ISCAS members. The 2013 Code continues to focus on local resolution, first directly with the service provider (stage 1) and then at a corporate level (stage 2). The Code sets out the standards that ISCAS members agree to meet when handling complaints about their services. Each year ISCAS sees the vast majority of complaints amongst its members are being resolved at either stage 1 or stage 2.



Adjudication with ISCAS is the stage 3 independent review process for complaints that an ISCAS member has not been able to resolve at stages 1 and 2. It is the only complaints Code offering this level of independence operating in the independent healthcare sector.

The healthcare sector is facing increased regulation from system regulators such as the Care Quality Commission and scrutiny of quality following both the Francis Report, the Review of the Regulation of Cosmetic Interventions, conducted by Professor Sir Bruce Keogh, and also the Winterbourne View report. Fundamental to the drive for quality is ensuring that the best procedures are in place for managing disputes.

ISCAS is already recognised by major regulators, including the Care Quality Commission (CQC), Health Inspectorate Wales (HIW), Healthcare Improvement Scotland (HIS) and the Regulation and Quality Improvement Authority (RQIA). CQC and HIW even signpost complainants to the service where appropriate.

Over the year ISCAS saw a small increase in membership from 68 organisations to 71. Of note many organisations have a large number of hospital services in their corporate membership of ISCAS, for example the largest has 68 hospitals.

ISCAS Complaints Code of Practice

The Complaints Code is the cornerstone of ISCAS and the review of the Code has been the focus of development work over the year. The new Code has a different approach and look, providing clear standards of what to expect for everyone that uses it. The effective 3 stage approach has been retained as it affords greater opportunity for local resolution.

The review of the Code included a consultation with the ISCAS Governance Board, ISCAS members and then a wider external consultation. This latter phase ensured ISCAS engaged with regulatory bodies, medical defence organisations and importantly with patient groups. The patient groups largely welcomed the changes to the Code but wanted ISCAS to be much clearer about the interface between complaints and clinical negligence, which led to further changes. It is important to reduce barriers for complainants as they work their way through a complaints process and the new Code strives to achieve this.

The Code has retained the prescribed timescales unlike the NHS framework, as these have proven helpful in managing complaints for both ISCAS members and complainants. A major change is how the Code takes account of potential clinical negligence issues within individual heads of complaint. Under the previous Code, complaints that involved potential clinical negligence, and in particular if a legal claim had been made, would have halted the whole complaints process. This is no longer the case with the new Code and ISCAS recommends that the complaints procedure, including stage 3, continues even if a complaint relates to matters that may give rise to a potential claim.

ISCAS also responded to feedback to increase the time a complainant has to escalate their complaint at each stage. Complainants now have up to six months to escalate complaints at each of the three stages. The Code was published in June 2013 and members had until September 2013 to comply with the changes.

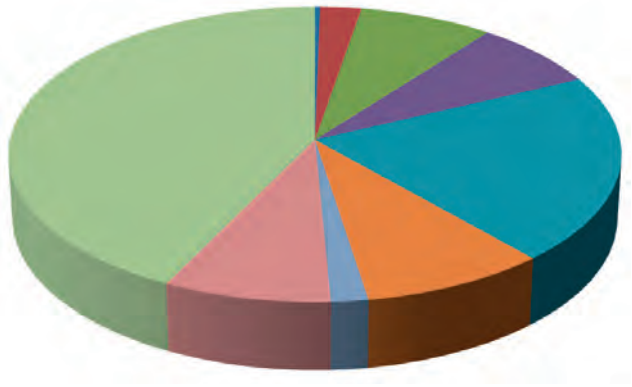
ISCAS Secretariat and Complaint Activity

by Andrew Wilby

Table 1: How people hear about ISCAS

329 people contacted ISCAS about their complaint over the reporting year in addition to complainants referring their case for adjudication. Table 1 shows how people were signposted to ISCAS however, 43% of all contacts could not recall, or were unsure where they learnt about ISCAS. From the remainder, the vast majority (21%) were using the internet and found the ISCAS website, which demonstrates the importance of continued development of this information resource. Fewer people were relying on the patient leaflet than has been the case previously.

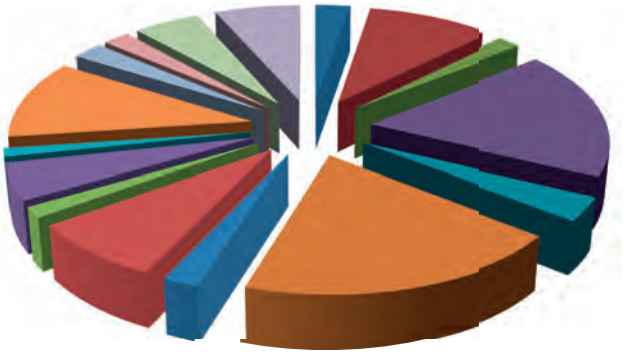
Table 1: How people hear about ISCAS, Referral Source.



- 0% AvMA
- 21% Internet / website
- 2% Citizens Advice Bureaux
- 9% ISCAS patient leaflet
- 8% Care Quality Commission
- 2% Patients Association
- 7% Health Service Ombudsman
- 8% Other not specified
- 43% Not recorded

Table 2 clearly shows that most of the people contacting ISCAS had a complaint in relation to cosmetic surgery, followed by complaints about consultant care.

Table 2: Complaint by type for all contacts at stages 1 and 2



- Clinical care 10%
- Lasers 5%
- Complaints handling 2%
- Mental health 1%
- Consultant care 18%
- Multiple complaints 11%
- Cosmetic treatments 3%
- Nursing care 2%
- Cosmetic surgery 19%
- Social care 2%
- Dental 2%
- Not Disclosed 5%
- Fees 8%
- Other 7%
- Insurance 1%
- Bariatric 3%

Table 3: Complaint by type for ISCAS members

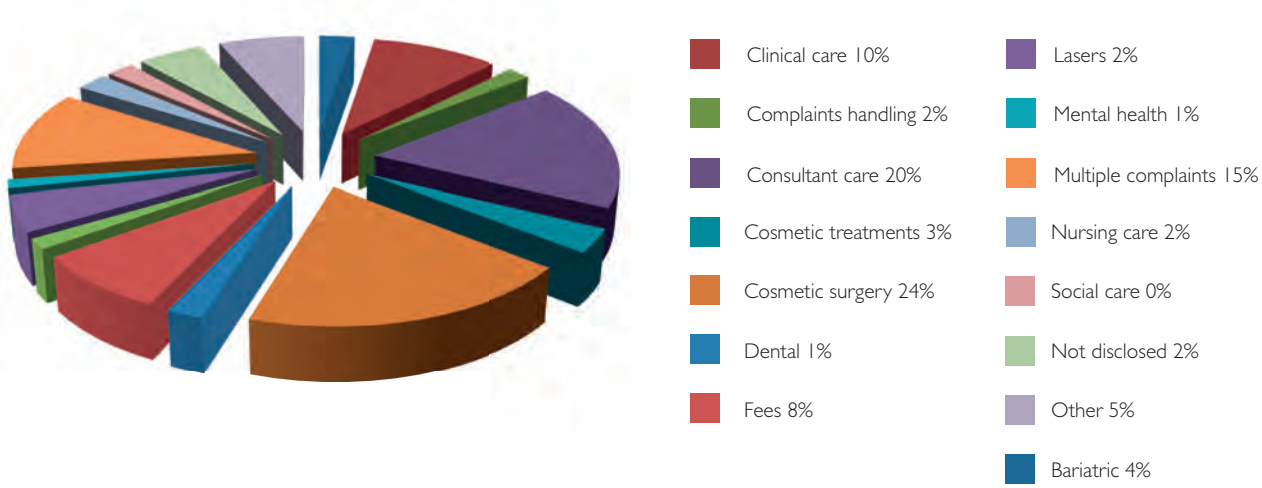
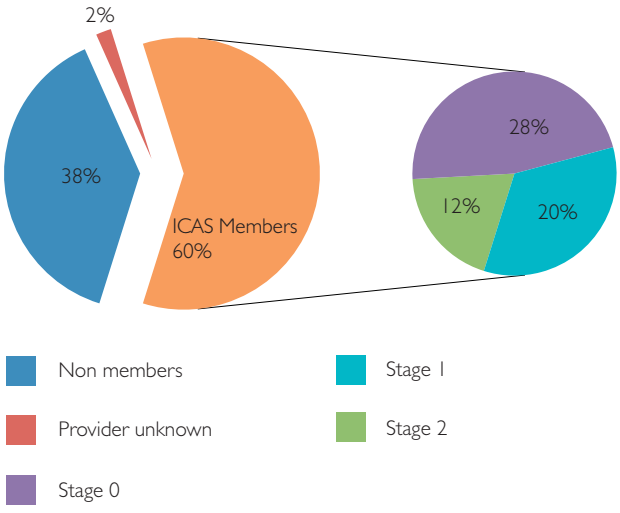


Table 4: Breakdown of complaints by each stage for ISCAS members

Table 4 also shows the stage that the complaint had reached when people contacted ISCAS.



Some people contact ISCAS before embarking upon the complaints process (28%), which reflects that in some cases the ISCAS member has not publicised their complaints information effectively. Some people seek assurance about how the complaint process is working.

ISCAS had a significant increase in complaints about non-members: 38%, compared with 25% last year. This includes people seeking to complain about NHS Private Patients Units, which do not currently subscribe to ISCAS. The remit of the Health Service Ombudsman does not extend to complaints about these units, leaving users of these services with limited redress and no avenue for independent review of their complaint. This is a matter the ISCAS Governance Board continues to raise with Ministers.

The majority of people contacting ISCAS about a member are at stage 1 of the process. Some are seeking advice about next steps and confirmation that the ISCAS member is following the right procedure. In some cases, there is a wish to escalate a complaint before stage 2 has begun. A significant amount of ISCAS time is committed to helping people work through the complaints process ahead of adjudication and to advising about alternative ways to pursue complaints about non-members. This is equally important to ISCAS, as unfortunately these complainants have used a service that has no commitment to a full complaints process with an independent review stage.

ISCAS Governance Board

Over the year, the Board has ratified the membership and focused on increasing its patient representation, including engagement with Action against Medical Accidents (AvMA) and the Private Patients Forum. The Board agreed a number of ISCAS developments to take forward:

- **Revision of the Code**
- **Seeking feedback from complainants about the service**
- **Improving the monitoring of member's compliance to the Code**
- **Reporting on ISCAS activity and adjudication outcomes**

ISCAS discontinued membership of one organisation due to continued non-compliance with the Code and providing a poor complaint service to its patients. This was an exceptional decision for the Board to make.

The Board's role in agreeing decisions about non-compliance is an important aspect of ensuring independence in the governance of the Code and demonstrating publically that membership of ISCAS means complainants are treated and responded to properly.

Baroness Fiona Hodgson, CBE, ISCAS Governance Board Chair

It has been my pleasure to chair the ISCAS Governance Board since its inception at its first meeting in March 2012.

This past year has seen the ISCAS Governance Board become well established. Getting the right balance on the Board has been an important concern. Coming from a patient background myself, I am always mindful about the importance of ISCAS engaging with patient representatives. During the past year we have invited in AvMA and the Private Patients Forum (PPF) in to talk to us about their work. We already have representation from the Patients Association and have been fortunate to have a patient representative from the Private Patients Forum.

Much work, and extensive consultation, has been put into the review of the Complaints Code of Practice. This has proved to be a challenging task which has meant that it has taken slightly longer to produce than originally anticipated. However, the new Code has been launched and I hope will be well received. I would like to thank Andrew Wilby and the ISCAS staff for all their hard work during the past year. Having such an excellent team has really helped the Governance Board enormously and we look forward to the challenges of the year ahead!

Baroness Fiona Hodgson, CBE

Independent Adjudication

Since reporting last year on the appointment of Sally Williams, ISCAS has been successful in confirming a second adjudicator, Fiona Freedland.

Fiona Freedland is a solicitor who specialises in the field of medical law. She played an active role in the Shipman Inquiry and in policy work regarding the regulation of healthcare professionals.

For many years, Fiona worked in the field of law and healthcare policy as Legal Director for AvMA, a national charity for patient justice. In addition to her work for ISCAS, Fiona is an Adjudicator for the Solicitor's Regulation Authority and sits as a Chair of the Nursing and Midwifery Council Fitness to Practice Panels. She is a lay assessor for the National Clinical Advisory Service (NCAS). Fiona has a masters degree in Medical Law and Ethics and she undertakes several public speaking roles on the subject of Medical Law and Ethics which is a particular interest of hers. She is an accredited mediator with CEDR.

Learning from Complaints During 2012-2013

Sally Williams, Adjudicator

An important and valued outcome of the complaints handling process is taking action to improve services and prevent the same problems happening again. Whenever an independent adjudicator reaches a decision on a complaint, they send a decision letter to the complainant and copy this to the ISCAS member the complaint was about.

The letter to the ISCAS member usually contains advice on how the organisation could improve its complaints handling. Often ISCAS members are asked to report back to ISCAS about actions they are taking as a consequence of this advice. In this way, independent adjudication seeks to be part of a circle of learning from complaints.

Where themes arise in the advice given to ISCAS members about specific complaints, these are shared with all ISCAS members through the Adjudicator's Monthly Message (this can be found at www.iscas.org.uk in the news section). Over the last year the monthly message has touched upon a broad range of issues. These include the thorny issue of complaints and clinical negligence. It is not uncommon for complaints to reach the adjudicator that stray into the field of clinical negligence, however ISCAS members often express uncertainty over whether the complaints procedures can continue where a complaint appears to have arisen as a result of possible clinical negligence and compensation is sought. The new ISCAS Code, published in June 2013, seeks to be clearer on this point and reflects practice in NHS complaints handling. It states: 'Even if independent advice is being sought about possible clinical negligence the ISCAS Code recommends that the complaints procedure and ultimately stage 3 adjudication is continued.'

Other themes from the year include the following:

1. Handling complaints received by email, including establishing a clear process for managing email interactions with complainants. This includes introducing timeframes that remove the pressure to give an immediate and, sometimes less considered, response and implementing a single database to log emails from the complainant and any organisational responses.

2. Demonstrating caution about what is contained in emails about complaints, which comprise an increasing proportion of complaints files and are potentially disclosable under the Data Protection Act. The informality of email can lure users into disregarding rules about confidentiality and the transfer of sensitive information. In reality, the risk of confidentiality breaches of personal information is much greater.

3. Ensuring that protocols governing the storage of patient records are adhered to by consultants with practising privileges and that information sharing happens to support complaints handling. Missing records make it much harder to establish the facts of a case and can create suspicion of a cover-up. Gaps often occur around consultant's clinical notes or photographs and imaging taken by consultants.

4. The use of experts to advise on the clinical aspects of complaints, including the importance of independence and the absence of any conflict of interest, having a clear documentation trail, and transparency over the identity of the expert and the opinion they provide.

5. Managing complaints that involve third parties, such as clinical negligence lawyers or a professional regulatory body, including whether there are elements of the complaint that the organisation should answer regardless of whether other parties are involved, what purpose will be served by halting a complaints process while third party investigations take place, and how the interests of the complainant and those complained about are best served.

6. The potential to resolve complaints more swiftly by offering to meet with complainants early on. This can be helpful in resolving complaints in a collaborative way.

7. Greater use of templates to ensure that responses to complaints routinely contain the right information.

Goodwill Payments, Anonymised Vignette

When a complaint reaches stage 3, the independent adjudicator is able to consider a wide range of remedies, of which one is to award a goodwill payment. Under the new code a goodwill payment can be awarded 'in recognition of shortfalls in the complaint handling, inconvenience, distress, or any combination of these, up to a limit of £5,000'. Often the award of a goodwill payment reflects all of these things, but issues have arisen over what the phrase 'shortfalls in the complaint handling' means in practice.

One case that illustrates this point concerns a complainant who underwent major surgery. Pre-operatively, the patient had been assessed as having three factors that increased her risk of Venous Thromboembolism (VTE) and identified her as needing anti-embolic (TED) stockings from admission until she was fully mobile. However, when she arrived at hospital, stockings in this patient's size were not available. Alternative mechanical prophylaxis was used to assist the prevention of VTE, but this was for only 24 hours and she was discharged from hospital without any support stockings. On two occasions after discharge home, the patient complained to hospital nursing staff about pain in her upper legs; these concerns were not escalated to her consultant. When she saw the consultant, he diagnosed bilateral deep vein thrombosis (DVT) and she later developed a pulmonary embolism (PE).

It was beyond the scope of the complaints procedures to establish whether the absence of support stockings caused, or contributed, to the development of this patient's DVTs and, subsequently, the PE. The adjudicator instead focused on how the hospital responded to the issues raised by the complainant, and found that the hospital did not respond adequately regarding its failure to provide the stockings that the patient had been identified as needing, that there was no evidence that consideration was given to postponing the procedure, and that it was not clear why stockings were not provided for use post discharge. The adjudicator also found that this patient was not well served during interactions with nursing staff post-discharge.

Positively, the handling of this complaint had been within the timeframes set out in the code and the adjudicator did not uphold heads of complaint that related to specific aspects of complaint handling. However, complaints handling covers the whole process, from responding to complaints within timeframes, the investigation and inquiry, as well as the remedies offered to the complainant. The adjudicator considered that as part of remedying the core complaint as set out above, the hospital should have made a gesture of goodwill.

The hospital considered the goodwill award made by the adjudicator – which fell into the category of 'very serious' – to be 'excessive'. It was concerned that the adjudicator had implied causality between the care delivered by the hospital and the complications the patient had experienced, and thought this was reflected in the goodwill payment awarded. The hospital was concerned that in paying the award, it risked implying acceptance of causality should the patient proceed to litigation.

The adjudicator responded that the size of the award reflected the seriousness of the issues and the distress caused to the complainant and her spouse. Paying it need not imply any acceptance of causality and appropriate caveats could be attached, such as expressly stating that it was made on an ex gratia basis, without prejudice and without any admission of liability. It was therefore incorrect to suggest that it would prejudice any clinical negligence claim in the event that the complainant decided to pursue this avenue.

This case highlighted the difficult path that ISCAS members and adjudicators often tread when handling complaints about issues that could potentially give rise to a clinical negligence claim. It also exposed a lack of transparency about the basis for determining the size of an award. This is something that the team of adjudicators are planning to address with ISCAS by developing guidance on the type of circumstances in which an award may be appropriate and the factors to consider in deciding the level of award. Such guidance can only be indicative, as each case must be considered on its own merits, but it should help to increase transparency of the formulation of awards.

Adjudication, Facts and Figures

The number of heads of complaint has risen since last year and may, in part, explain the increasing complexity of many of the cases that come to adjudication (Table 5). Last year, for the first time, adjudication saw more complaints about nursing and a decrease in medical complaints. This year there was a return to a higher number of medical complaints, as seen in table 5. It is important to note that these are complaints that are not resolved at stages 1 and 2; they do not necessarily reflect the scope of complaints received at those earlier stages by ISCAS members.

Complaints relating to administration, which includes complaints handling, have always been significant, however they have increased this year following a slight decrease last year. This has implications for how members comply with the code, which has led to the adjudicators recommending that ISCAS has oversight of actions taken by members organisations to improve complaints.

Table 5: Total heads of complaint year on year

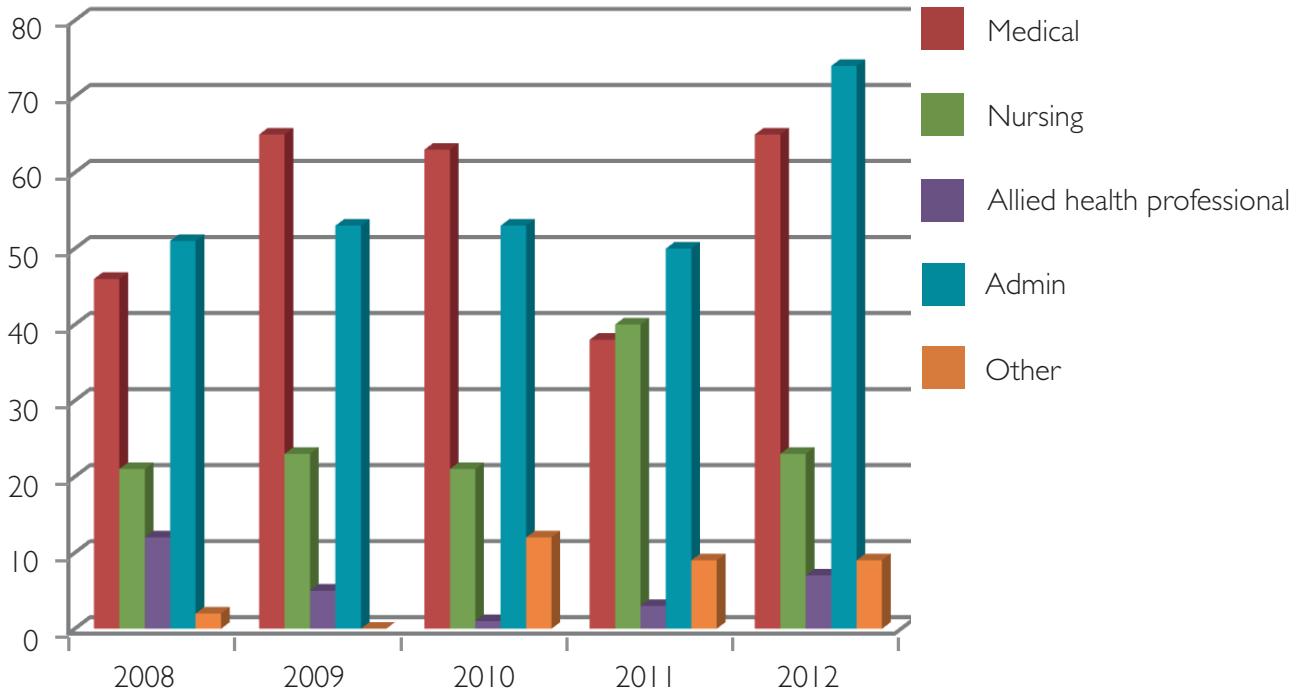


Table 6: Heads of complaint upheld by Independent Adjudication

48% heads of complaint were upheld under Independent Adjudication:	
Medical	33% of all medical complaints were upheld
Nursing	43% of all nursing complaints were upheld
Allied health professional	42% of all AHP complaints were upheld
Administrative	66% of all administrative

Expert Clinical Advice

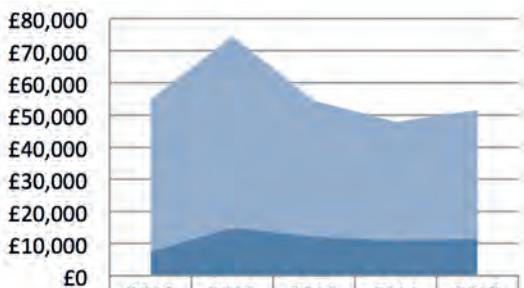
The use of expert advice is essential when a case involves a clinical matter that an Adjudicator needs to make a decision about, and demonstrates to the complainant the evidence and rationale the Adjudicator has relied upon. This year saw a rise in the number of cases requiring expert clinical advice from just 1 of the 28 cases last year to 8 of the 38 cases in 2012/13. The total costs associated with the expert advice came to £6,646.

Costs of adjudication

Since 2009 the cost of adjudication has reduced. However, during 2012 the overall cost rose slightly, which is shown in Table 7. There are a number of reasons for this. There has been an increase in the total number of cases coming to adjudication (Table 7). As noted previously, the cases coming to stage 3 adjudication are increasingly complex in nature, which has resulted in an increase in the resource required to complete an adjudication. ISCAS had for five years made no increase in the fees paid to the adjudicators and 2012 saw a reasonable increase in these fees. Such costs are met by the ISCAS members and adjudication remains free to complainants, as is the case with the Health Service Ombudsman.

Table 7: Year on year adjudication costs

The Code has a focus on learning and improving from complaints although it does allow the Independent Adjudicator to make a goodwill payment in recognition of inconvenience and distress. Table 9 shows there has been a slight decrease in the number of cases where a payment was made (down from 57% to 50%). The average cost of a payment was higher in 2012 compared with 2011, but was less than in previous years. The maximum payment that can be awarded is £5000, although the majority of cases that attract the payment are between £150 to £500. The maximum awarded for a single adjudication case was £3000.



	2008	2009	2010	2011	2012
Adjudication	£47,270	£59,485	£42,203	£36,950	£40,103
Ex Gratia Awards	£7,540	£15,000	£12,150	£10,906	£11,500

Table 8: Goodwill payments

Goodwill payments made	2008	2009	2010	2011	2012
Cases in which payments made	14	21	17	16	19
% of cases attracting a payment	72%	78%	77%	57%	50%
Total cost payment £	7,450	15,000	12,150	10,906	11,500
Averrage cost payment £	573	714	714	390	605

The Year Ahead

Over the next year we will be reviewing the governance of ISCAS to continually improve the service. The governance arrangements of the Board will be further developed, including a commitment to increase the patient and public representation. ISCAS is seeking to raise its profile in the healthcare sector, firstly with a formal launch event of the ISCAS Code to sector stakeholders. ISCAS members are also likely to experience increased monitoring of their compliance with the Code as an integral part of membership application and renewal.

Management Accounts for 2012 - 2013

ISCAS	To 30/04/13
Subscriptions (£)	52,714
	52,714
Direct expenses	38,455
Gross profit /(loss)	14,259
Overheads	20,735
Net profit / (loss)	(6,476)

ISCAS is a not for profit scheme that reviews member subscriptions on an annual basis, with the intention that member subscriptions will cover the ISCAS operating costs.

Appendix 1

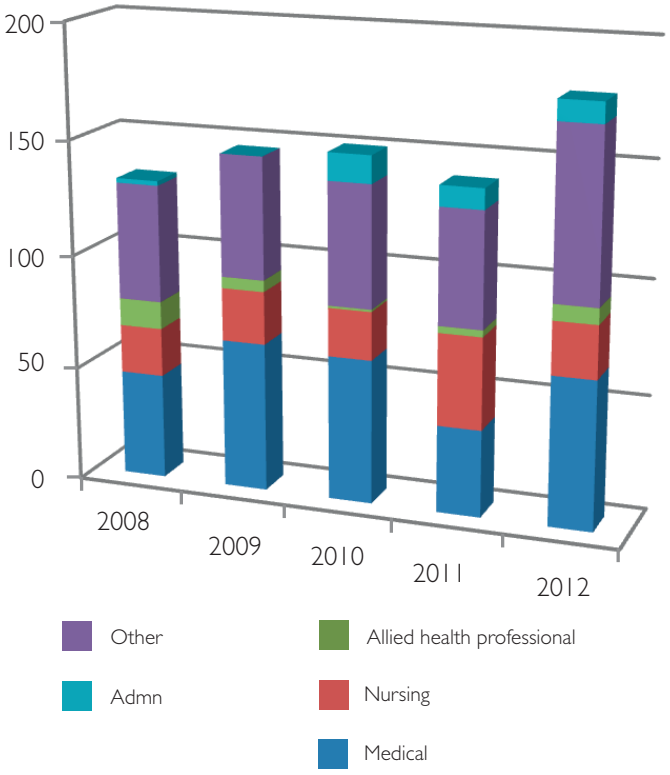
Table 9: Total number of complaints and by complainant type

	2008	2009	2010	2011	2012
Total number of complaints adjudicated	18	27	22	28	38
Total heads of complaints	132	146	150	140	178
% Female complainants	72%	63%	82%	64%	66%
% Male complainants	28%	37%	18%	36%	34%
Adjudication panels held	0	0	1	0	0

Table 10: Heads of complaint year on year

	2008	2009	2010	2011	2012
Total heads of complaint	132	146	150	140	178
Medical	46	65	63	38	65
Nursing	21	23	21	40	23
Allied health professional	12	5	1	3	7
Admin	51	53	53	50	74
Other	2	0	12	9	9
Total heads ofcomplaint not upheld	106 53%	77 61%	89 59%	73 52%	95 53%
Medical	38	34	36	24	43
Nursing	15	11	12	15	13
Allied health professional	12	3	1	1	4
Admin	39	29	32	30	27
Other	2	0	8	3	8
Total heads of complaint upheld	26 20%	69 47%	61 41%	68 48%	83 47%
Medical	8	31	27	14	22
Nursing	6	12	9	25	10
Allied health professional	0	2	0	2	3
Nursing	12	24	21	20	47
Other	0	0	4	7	1

Table 11: Nature of heads of complaint coming to Independent Adjudication



ISCAS Members

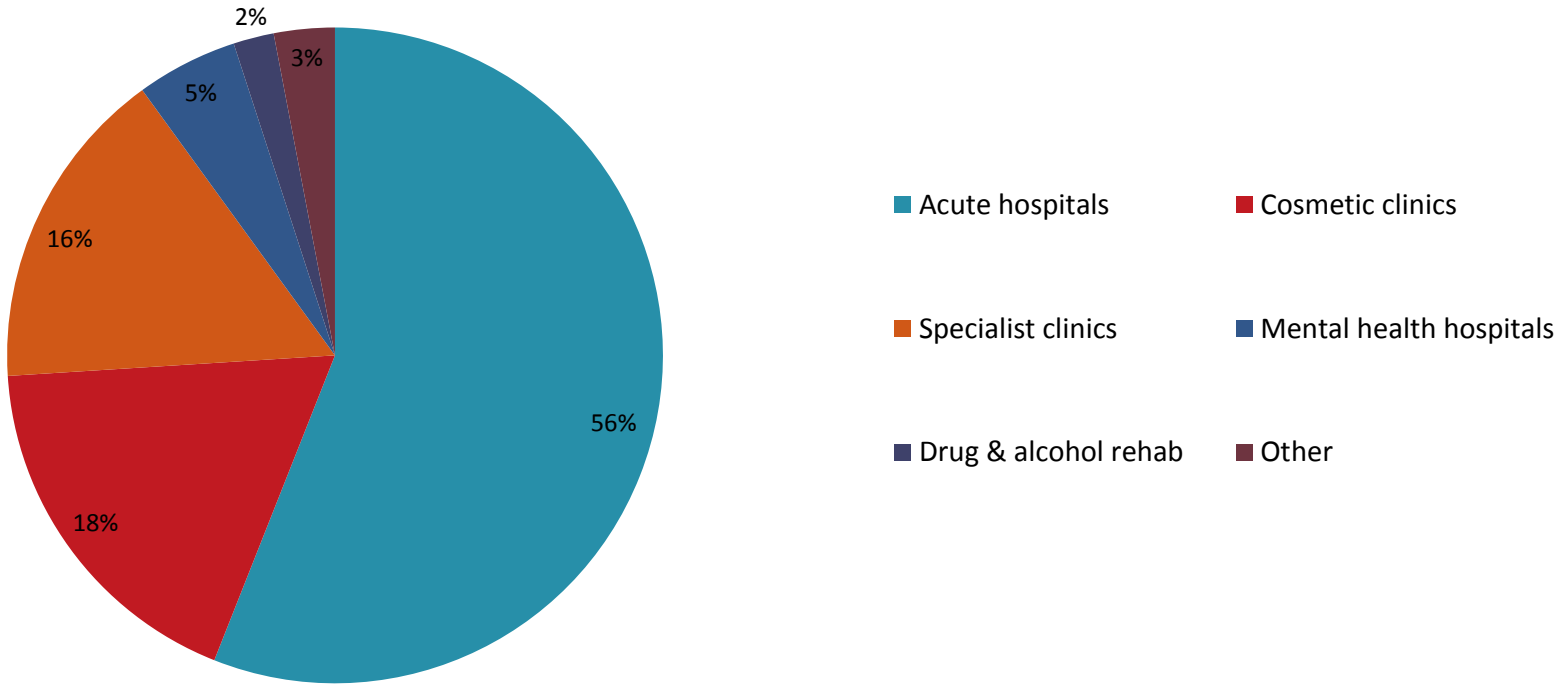
- Aspen Healthcare Group
- Ayr Partnerships in Care
- Benenden Hospital Trust
- BMI Healthcare
- Bupa Cromwell Hospital
- Cambian Group
- Castle Craig Alcohol & Drug Rehab Clinic
- Castlebeck Care (Teesdale) Ltd
- Circle Partnership UK
- Clock House Healthcare Limited
- Destination Skin
- Linia
- Fairfield Independent Hospital
- Glenside Hospital
- HCA International
- Huntercombe Hospital - Edinburgh
- Independent Doctors Federation
- King Edward VII Hospital Sister Agnes
- Lighthouse Phoenix House, Welshpool
- Llanarth Court Partnerships in Care
- Ludlow Street Healthcare
- Make Yourself Amazing
- Marie Stopes International
- Mental Healthcare UK Ltd
- NE Oasis
- New Life Clinic
- New Victoria Hospital
- Newport Cardiac Centre
- North West Independent Hospital
- Nucleus Healthcare (now closed)
- Nuffield Health
- Ophthalmic Surgery Centre (North London) Ltd
- Ramsay Health Care UK
- Rushcliffe Care Group
- Sancta Maria Hospital
- Scottish Epilepsy Centre (Quarriers)
- SERCO Health
- Sk:n Ltd
- Spencer Private Hospitals
- Spire Healthcare Ltd
- St. Joseph's Private Hospital
- Surehaven Glasgow
- The Alexander Clinic
- The French Cosmetic Medical Company
- The Horder Centre
- The Hospital Group
- The Hospital of St John and St Elizabeth
- The London Clinic
- The Medical Chambers Kensington Limited
- The Priory Group of Companies
- The Raphael Medical Centre
- The Royal Hospital for Neurodisability
- Transform Medical Group
- UK Specialist Hospitals
- Ulster Independent Hospital
- UME Diagnostics
- Vale Healthcare Ltd
- Your Excellent Health Service

Briefing on ISCAS
Finance Committee Hearing - 4 February 2015

Membership of ISCAS

- ISCAS deals with complaints related to privately-funded treatment
- 98% of all UK regulated independent healthcare providers
- 57 members across the UK – 234 individual hospitals/clinics at last count
- 5 providers joined ISCAS in 2014

ISCAS Members – types of provider



Key ISCAS documents

- Cornerstone is the Code of Practice (2013)
- Patient Guide for Making Complaints (2014)
- Adjudicators Goodwill Payments Guide (2014)
- All available on the ISCAS website: www.iscas.org.uk

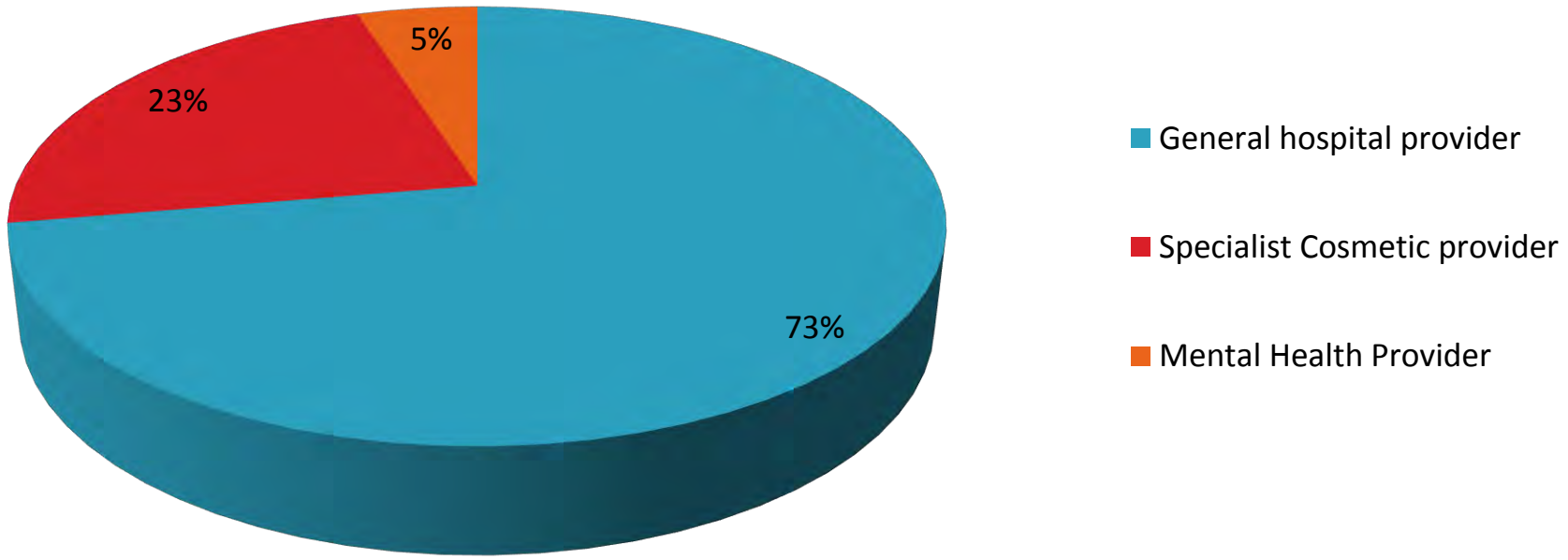
Stage 1&2 contacts to ISCAS in 2014

- 320 people contacted ISCAS re a complaint
- 63% of contacts concerned ISCAS members

- 70% of referrals came from four sources:

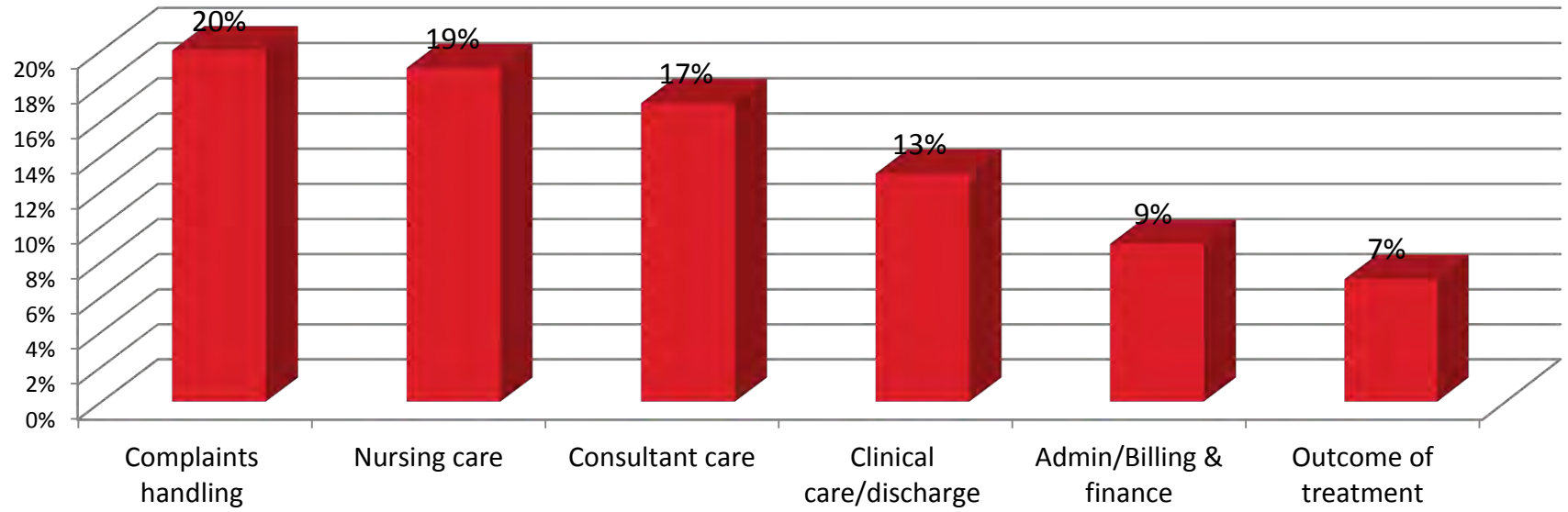
Stage 3 Adjudication

40 Stage 3 Adjudications in 2014



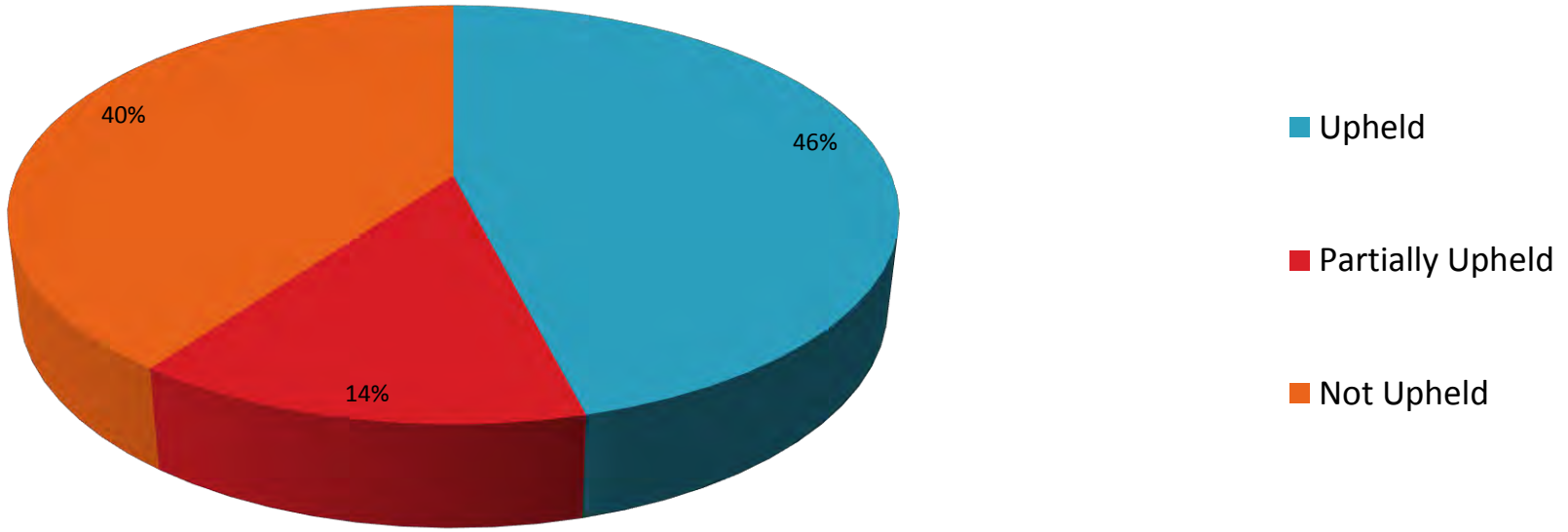
Heads of Complaint at Stage 3

- A total of 151 Heads of Complaint were adjudicated on in 2014.
- Breakdown of 85% of Heads of Complaint :



Findings on Heads of Complaint

Adjudicator Findings on the 151 Heads of Complaints



Stage 3 Adjudication Costs 2014

- Individual members bear the cost of adjudications.
- Average cost of an adjudication was £2430.
- Goodwill payments made in 88% of cases.
- Average size of a goodwill payment was £400.
- Range of goodwill payments awarded was from £100 to £1500.

ISCAS Services - The Way Forward

- Increasing the two-way dialogue with ISCAS members
- Guidance for members on what to include in your complaints policy
- Continuing information sharing with the CQC and extending this to all healthcare regulators
- Regular compliance checks on members
- Consultation with members on the Code of Practice

Review of the Code of Practice

Issues from the ISCAS Management Team:

- Delays in completing Stage 2 Reviews
- Clarity on exceptional circumstances that would extend the time limit for investigating a complaint.
- Engagement with CEOs at the Stage 3 level.

Review of the Code of Practice

Considerations arising from the Patients Association's criticisms of the PHSO

- Appeals to Stage 3 Adjudication.
- Demonstrating change has occurred as a result of adjudication
- Face to face to meetings between complainants and Adjudicators
- Draft decision letters sent to complainants for comment

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How ISCAS Stage 3 Adjudication Works

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1. Who we are, what we do, how we do it

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Who we are

- Currently three independent adjudicators
- Variety of backgrounds, including health policy, health professional standards, complaint handling, consumer policy, regulation and the law
- ISCAS looks for adjudicators with the skills and competencies required for the role, including:
  - demonstrable integrity
  - experience and ability of reaching considered and unbiased decisions affecting other people
- Impartiality

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What we do

- Complaints Code of Practice (2013) – 3 stage process
- Review and make decisions on complaints by people who are not satisfied with the results of the internal complaints-handling processes of the hospital or clinic that provided their care
- In other words, the complaint must have exhausted the provider's two-stage process:
  - Stage 1 – local resolution
  - Stage 2 – internal complaint review
- Independent adjudication is Stage 3 – the **final stage of the process**

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How we do it

- Desk-based review of all the documentation associated with a complaint
- Draw on expert advice for clinical aspects of complaints
- Issue decisions in the form of a ‘letter’ to the complainant and the ISCAS member

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1. Complaint escalated to ISCAS

- ISCAS confirms stage 2 has been completed, seeks consent for release of documents, requests file from provider

2. Complaint file sent to Adjudicator

- Acknowledge receipt of file
- Undertake preliminary review – identify gaps, decide whether expert advice might be needed

3. Review documentation

- Prepare chronology
- Note observations as go through it
- Pay attention to timeframes
- Flag any breaches of Code

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4. 'Key heads' letter

- Set out understanding of main concerns – ask complainant to highlight anything misinterpreted or overlooked
- Address outcome sought
- CQC

5. Questions for expert

- ISCAS instructs expert and agrees fees
- Adjudicator sets out questions under the relevant head of complaint
- Share chronology

6. Prepare adjudication

- Informed by examination of documentation
- Draw on expert report
- Decisions made in isolation

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When the complaint has been decided upon, the Adjudicator submits six documents to the ISCAS team

- Decision 'letter'
- Covering letter to provider
- Data sheet for ISCAS
- List of all those named in the decision letter
- Chronology
- Invoice

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Post-decision

- Note any positive feedback

'Thank you very much for reviewing this matter in such comprehensive detail.'
Complainant

'I am really happy that you responded to my complaint and investigated my case.'
Complainant

'I am extremely grateful to ISCAS for providing the opportunity for a proper and full investigation of my husband's treatment.'
Complainant

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Post-decision

- Note – and learn from – any negative feedback

'I am not disappointed but disgusted with your decision.'
Complainant

'I am not the problem it is the regulation of the plastic surgery industry that is the problem and until this happens more and more cases like mine will land on your desk.'
Complainant

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Post-decision

- Signpost other organisations – e.g. General Medical Council, right to seek legal advice

- Emphasise finality of decision and completion of complaints process

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2. Underpinning aims: Agile, responsive, transparent and fair

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'Dealing with complaints. Easy, 6 steps; listen, sympathise, don't justify, make notes, agree a course of action and follow through.'

Roy Lilley, *nhs*Managers.net, 22 January 2015

Can it be this simple?

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Stronger stage 3 review

- Revising the documentation sent to complainants
  - Including the format of adjudication decision letters
- Standardising the approach to capturing the key heads of complaint
  - Developing a ‘heads of complaint library’
- Redesigning the way we instruct experts

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3. Goodwill payments

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'Most of those who complain about NHS services do not seek financial redress. They do so because they wish to have their concerns and experiences understood and for any failings to be acknowledged and put right so that others do not suffer the same avoidable harm.'

House of Commons Health Committee, 13 January 2015

Do people who complain about private healthcare seek these same outcomes?

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Discretion

- Independent Adjudicators have the discretion to award a goodwill payment of up to £5,000.
- Primary purpose: to reflect any distress or inconvenience arising from the issues complained about, or as a result of pursuing the complaint
- NOT a refund or compensation – beyond the complaints process to establish causation, liability or negligence (concepts tested in court)
- BUT do take into account offers or reimbursement made by provider
- Focus on whether service fell below the standards that could reasonably be expected

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Goodwill Payments Guide

- Compliance with the Code (e.g. minor or significant breaches)
- Time taken to respond to the complaint
- The provider's response (e.g. tone / substance of responses)
- The complainant's actions (e.g. whether delays partly caused by complainant)
- Nature of complaint (e.g. isolated failing v. repeated problems)
- Impact on complainant (e.g. distress, inconvenience, pain and suffering)
- Other factors (e.g. financial burden arising from making complaint)

Provider's response to the complaint

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Mitigating factors	Aggravating factors
Evidence that complaint has been taken seriously (e.g. proper investigation, attempts to resolve expeditiously)	Lack of evidence that complaint has been taken seriously /insufficient investigation
Tone of responses was constructive, empathetic and sincere	Tone of responses was unhelpful to the resolution of the complaint
Attempts made to remedy at an early stage (e.g. sincere apology, steps to rectify, review appointment offered)	Little evidence of attempts to remedy
Action reported to prevent recurrence/improve services and/or identify shortfalls	Complainant was required to take additional or unnecessary steps

Goodwill Payments Guide

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- Four tier scale

Scale	
Tier 1 (moderate)	Up to £500
Tier 2 (significant)	£500 - £1,000
Tier 3 (serious)	£1,000 - £3,000
Tier 4 (very serious)	£3,000 - £5,000

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4. Identifying learning

Examples of learning – complaints

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- Weaknesses in the investigation of complaints at local level
  - Failing to gathering statements from doctor providing treatment
  - Failing to document evidence in a systematic way
  - Statements that are unsigned and undated
- Breaches of the Code
  - Timeframes tends to be a particular issue
- Lack of process for dealing with communications from complainants by email
  - Complaints management can quickly unravel without a clear process here

Examples of learning – services

- Failure to give sufficient attention to recording the detail of conversations about consent
  - Doctors' clinical notes sometimes give scant reference to risks
  - Notes closed to scrutiny by illegible handwriting
  - Consent forms often have the appearance of being written in haste
- Misleading or exaggerated claims about the skills and experience of doctors
  - E.g. describing one doctor as a 'surgeon' and a 'specialist Gynaecologist and Obstetrician' who was not on the General Medical Council's specialist register and was in fact a GP

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Escalating concerns

- Concerns over how ‘Patient Coordinators’ were being used in one cosmetic surgery organisation
- The number of telephone calls another cosmetic surgery organisation made to a prospective patient
- Failures by one hospital group to deliver the distinct two-stage complaint process The impersonal and anonymous letters of response sent by one provider

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18 March 2015

Sent by email and post

Jocelyn Davies AM
Chair of the Finance Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Dear Ms Davies

ISCAS information on Private Patient Units

During the Oral Evidence session I had with the Finance Committee, I stated that I would provide the Committee with a paper produced by the Department of Health about how complaints made by patients in private patient units (PPUs) in England are regulated.

Unfortunately I have subsequently learnt that this paper has not in fact been produced due to the workload of the civil servant concerned and therefore I am unable to provide this to the Committee.

However, the Independent Sector Complaints Adjudication Service's understanding of the Department of Health's position is that PPUs fall within the definition of NHS Trust's 'functions' bringing them within the scope of the complaints regulations, and this covers healthcare staff supporting PPU activity on NHS terms and conditions. However, if a consultant or other healthcare staff have entered into a direct arrangement with the patient or representative, it falls outside the regulations.

I hope that is helpful and I look forward to receiving a copy of the Committee's final report.

Yours sincerely

pp. Sally Taber
Director

Connah's Quay Town Council

Ian D Jones
Clerk of the Council & Financial Officer

Tel: 01244 819420
e-mail: cqtcclerk@connahs-quay.co.uk or info@connahs-quay.co.uk
www.connahs-quay.co.uk

IDJ/OMB1

11 February 2015

Committee Clerk
Finance Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Dear Sir/Madam

Consultation on an Inquiry into the Consideration of Powers of the Public Services Ombudsman for Wales

The Town Council would like to make the following comments in relation to the questionnaire:-

1 Ability to utilise the Ombudsman facility/service for help and advice especially if other means fail to address a situation.
2 This would help where person/persons did not feel compelled or comfortable to complain, however the mere fact that the Ombudsman initiates an investigation begs the question how would the Ombudsman know about a potential situation worthy of investigation and the initial facts about the case.
3 Yes there are some concerns (see 2 above) ie in what circumstances would this be initiated. There could be an overlap eg with local internal investigations or Monitoring Officer etc. This could be managed through effective and confidential communications as necessary.
4 Costs could be prohibitive especially if the Ombudsman could instigate many own-initiative powers.
5 In writing would be the best way however oral complaints should be considered initially to see if there was merit or justification for taking things forward.
6 Any modern or traditional forms of communication.
7 Costs could be prohibitive, however in some cases the benefits of a successful and effective intervention/result of investigation may be worth the cost, which is a matter of judgement.
8 A model complaints policy would be useful to some organisations but a one-size fits-all approach may not be feasible, therefore policy guidance and a model code should be mandatory to be adopted only where possible to implement. This should also lead to some consistency in approach no matter the size and composition of the public body.
9 There should be little cost in drawing up a model code and the benefits would be seen countrywide where public bodes do not have the resource, expertise or inclination to draw up their own code.

10 Current jurisdiction seems about right.
11 Agree with this proposal to take up the individual's complaint whether self-funded or commissioned.
12 Means tested - levy charge as appropriate (eg free for low income OAP's).
13 Case by case if a fee was charged it would deter vexious or unfounded cases. Fees should cover all investigations and help support the free investigations.
14 Statutory Bar should be removed to allow the Ombudsman to advise the complainant on the best course of action
15 Yes as a last resort, to gain a determination on the legal status and for the avoidance of doubt.
16 Consideration should be given to a charging structure to be fair and income-related.
17 None locally.
18 All bodies that are public representative.
19 Within 12 months.
20 This legislation could lead to a huge rise in the number of complaints both orally (new) and in writing. The office of the Ombudsman could be overcome with workload thus being ineffective to deal with the serious complaints adequately, effectively and within a reasonable timespan. Checks and balances must be put in place to effectively filter unfounded, vexious and malicious complaints out of the system if the Ombudsman is to be effective and maintain reputation.
21 Financial and effectiveness of provision.
22 Jurisdiction seems fine at present. Recommendations should take into account the body's ability to respond. Ombudsman title should be protected for the avoidance of doubt in the public eye. Council's do vary on practices and procedure but most will have Codes in place and should abide by them which effective guidance from Officers. Any changes/re-organisations should coincide with a release (and reminder) of information from the Ombudsman. No further views on the Act and reform.

Yours faithfully

IAN JONES
Clerk & Financial Officer

Connah's Quay Town Council

Ian D Jones
Clerk of the Council & Financial Officer

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Cyngor Cymuned
MOCHDRE gyda PHENSTRYWAID
MOCHDRE with PENSTROWED
Community Council

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Committee Clerk,
Finance Committee,
National Assembly for Wales,
Cardiff Bay,
CF99 1NA

Date: 11th February, 2015

Dear Sir,

Re: Proposed Amendments to the Public Services Ombudsman (Wales) Act 2005

I have been instructed by the council to forward its response with reference to the above:

The council is in full agreement of speeding up the service provided by the Ombudsman (in particular by introducing the provision of access via oral complaints). However, it is very concerned at the cost of change which seems inordinately high, particularly the salaries quoted. The council asks for clarification as to why the salaries are set at such a high rate.

Yours sincerely,

K. Wigley.

Kath Wigley
Clerk to Mochdre with Penstrowed Community Council

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Jocelyn Davies AM
Finance Committee Chair
National Assembly for Wales

19 February 2015

Dear Jocelyn

Thank you for the opportunity to submit comments to the Finance Committee's inquiry into the consideration of powers of the Public Services Ombudsman for Wales (the Ombudsman). You have specifically asked me to provide comment on the following:

1. **Could own initiative investigations by the Ombudsman conflict with the role of independent commissioners?**

   I believe there is an opportunity for the Ombudsman to be allowed to act in a more proactive role through for example own initiative investigations, especially where there is evidence to suggest from individual cases that there could be a wider public interest issue. Many older people tell me that they complain not just to resolve their own concerns but also to ensure that there is not a repeat occurrence of the same mistakes and to prevent the same thing happening to someone else or to someone else's family.

   I would fully expect that I would be consulted about any own initiative investigations which impact upon older people and be able to contribute towards the investigation and that any changes to legislation places on the Ombudsman a requirement to consult.

   I already meet with the Auditor General for Wales to share our intended work programmes, identify areas of common interest, minimise duplication of effort and resource and discuss how our two organisations can work to support each other to achieve shared outcomes for older people in Wales. This has been achieved without conflict and could work along similar lines with the Ombudsman.

2. **Is there a need for a co-ordination role between the independent commissioners, the Ombudsman and the Auditor General for Wales to help their investigations and recommendations to improve public services?**

I do already meet regularly through the year with the Ombudsman to discuss our respective casework and work programmes. There are also strong relationships with officers in both organisations that ensure that information about key investigations is shared.

Section 16 of the Commissioner for Older People (Wales) Act 2006 (the Act) covers 'Working jointly with the Public Services Ombudsman for Wales'. Section 17 covers 'working collaboratively with other ombudsmen' e.g. the Children's Commissioner for Wales and Welsh Language Commissioner for Wales.

The requirements of the Act address:

- Informing the Ombudsman about a case
- Consulting the Ombudsman about a case
- Co-operating with each other in relation to the case
- Conduct a joint examination of a case
- Prepare and publish a joint report

Underpinning the legislation we have developed a Memorandum of Understanding which sets out in more practical terms how we would work collaboratively together and extends to joint training, sharing information about trends and pro-active sharing of relevant reports.

The memorandum states that the overarching aim is to contribute to the development of excellent public services in Wales that respect and promote the human rights of citizens in Wales and are sensitive to the needs of the most disadvantaged and vulnerable members of society and make best use of public resources. I see no reason why this Memorandum could not be extended to cover own initiative investigations.

3. **Would the proposed reforms of the Ombudsman's role be better carried out in advance of wide public sector reforms, or after?**

I would favour any reforms of the Ombudsman's role to be carried out in advance of wide public sector reforms so there is no delay in investigating concerns raised by individuals.

Additionally I have also considered some of the other questions listed in Annex A to your request:

- **Oral complaints**

  Whilst I acknowledge the importance of a written record to support a complaint; insisting that a complaint is in writing before any action can be taken can create a barrier to some older people and others with protected characteristics that may need assistance in documenting a complaint.

  I would hope that in accordance with the principles and requirements of the Equality Act 2010, that reasonable adjustments could be made to allow people to make complaints by email, in person or by telephone that could later be confirmed in writing or through alternative means e.g. with support from an advocate or where relevant an interpreter.

- **Complaints handling across the public services**

  I would welcome a model complaints policy which all public bodies would be obliged to adopt, provided that the language used is accessible, there is a named individual appointed to investigate the complaint and that timelines for investigation and response are prompt.

  Whilst I would always encourage older people to trust in the complaints processes of public bodies, as this is a proven way that public bodies can learn from mistakes and strengthen their own processes, there can however be some cynicism and a model complaints policy would go some way to alleviate this concern.

  Any model complaints policy would however need to be supported by training and promotional materials for staff in public bodies and for people who use services. There would also be an impact on other organisations that provide support in making a complaint such as Community Health Councils and Citizen Advice Bureaux. I would be supportive of any move to improve the way in which complaints are investigated across public bodies in Wales.

- **Ombudsman's jurisdiction**

  My preference would be for the pathway followed by the individual to form the basis of the pathway of the complaint investigation and not be limited to just the public bodies along that pathway; individuals do not live their lives in such linear patterns.

  As the future model of public service delivery is likely to become more diverse and extend to social enterprises and other innovative public/private partnership arrangements then this pathway approach needs further consideration.

- **Links with the Courts**

  Many of the people that contact me are looking for restorative justice and an assurance that no-one has to go through what they have been through. Making a complaint can be a very emotional experience as can the pursuit of remedy through a legal challenge.

  Careful consideration must therefore be given to the best interests of the individual as to which are the most effective paths to follow. There needs to be honesty at the outset in what can and cannot be achieved. Support must be available to individuals during the complaints and legal process.

  It would be helpful to know the numbers of cases and examples of cases where the Ombudsman would have acted differently had the possibility of recourse been available.

  I can see merit in allowing the Ombudsman being able to refer cases to the Court for a determination on a point of law if it brings about a swifter resolution for an individual rather than having to go through a separate legal process to seek resolution.

- **Other issues**

  As highlighted in the evidence session I gave to the Silk Commission, alongside the then Ombudsman, there is a frustration that changes to the devolution settlement can mean an individual finds themselves having to follow more than one complaint process. It is important therefore that the jurisdiction of the Ombudsman be reviewed as the settlement changes to ensure wherever possible

the impact on the individual does not get lost between systems and processes.

I would lend my support to the recommendations of the Ombudsman being binding so that the impact of failure by public bodies is felt by those bodies and not just by individuals who have been failed by them.

Yours sincerely

Sarah Rochira
Older People's Commissioner for Wales

Mandy Evans
Clerc y Dref a Swyddog Cyllid /Town Clerk & Finance Officer
Cyngor Tref Abergele Town Council
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Good Afternoon

I have been requested to forward the following response on behalf of Abergele Town Council, with regard to the above:

Members did not agree with point 14 of the document – the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court.
The Ombudsman should be open and fair and registering of a complaint should be in writing. Members agree that adequate staff should be provided to ensure that the office is run efficiently.

One Voice Wales Consultation Response

CONSULTATION ON AN ENQUIRY INTO THE CONSIDERATION OF POWERS OF THE PSOW.

INTRODUCTION

One Voice Wales is recognised by the Welsh Government as the national representative body for community and town councils in Wales. It represents the sector on the Local Government Partnership Council and over three-quarters of the 735 community and town councils are already in membership, with numbers growing year on year. As well as our representative role, we also provide support and advice to councils on an individual basis and have previously launched, with Welsh Government support, a modular training programme for councillors. We believe strongly that community councils are well-placed to develop the economic, social and environmental well-being of the areas they serve and, as such, are active and proactive in debating key issues such as energy policies, environmental issues and strategic planning. Our sector is therefore well placed to contribute to a successful future nation, building community and public services from the bottom up.

GENERAL

Question 1 – The PSOW service is well established within Wales and its role is understood and respected by community and town councils. The service appears to work effectively and its decisions are communicated through the production of annual reports and full updates. The Code of Conduct guidance available to community and town councils is widely available and its content has been used in the development of training materials delivered by One Voice Wales.

OWN INITIATIVE INVESTIGATIONS.

Question 2 – Rigid procedural adherence is often necessary to protect both the complainant and the person(s) to whom the complaint has been made against. However, it is possible that on limited occasions, intelligence may be received which highlights concerns that might be harmful to individuals and for whatever reason the individual(s) find themselves powerless to complain in a formal sense. Such intelligence could be revealed through a range of sources (e.g. information from third parties, press reports etc.) and it is important that the PSOW has the power to investigate in order to assess whether there is a serious matter requiring investigation. It is important that individuals who may be unduly restricted for whatever reason from raising the alarm by way of making a complaint should be protected. Effective arrangements would need to be in place to require the PSOW to liaise with other relevant bodies such as the Police, Older Person' Commissioner etc.

Question 3 – There would inevitably be issues relating to over-lapping responsibilities and proper mechanisms would need to be in place to ensure that effective communication and co-ordination of activity was in place. It may be necessary to establish a forum of key players that would meet as necessary to consider the possible involvement of the PSOW in appropriate cases. There are many models in place within other sectors such as Case Conferences, MAPPA arrangements etc.

Question 4 – One Voice Wales has no particular view on the financial costs and benefits except to say that proper investigation of own initiative investigations could save time and money in the longer term but more importantly could prevent the continuation of poor practices which have adverse effects on individuals.

ORAL COMPLAINTS

Question 5 – The case made by the PSOW for enabling complaints to be submitted electronically or orally is compelling and it is vitally important that all members of society do not face unnecessary obstacles which might prevent them from having their complaint properly investigated. There will however, need to be some ground rules established to ensure the appropriateness of complaints not submitted in writing in order to prevent an escalation of vexatious type complaints where a proper assessment of the nature of the complaint has been given scant attention by the complainant.

Question 6 – E-Mail, website form and text messages should all be accepted as a legitimate means of complaint submission. In the case of oral submissions it is important that if necessary complainants in such cases should have the opportunity of an interview where the nature of their complaint would be recorded by a competent individual.

Question 7 – There could be additional costs involved in seeking additional information from complainants as electronic methods of making a complaint would not follow a questioning technique that is built in to complaints forms. There would also be additional costs associated with the arrangement of interviews for those who are unable to communicate in writing.

COMPLAINTS HANDLING ACROSS PUBLIC SERVICES.

Question 8 – One Voice Wales would support a model complaints and concerns policy becoming mandatory for public service bodies in Wales. In order to save on time and costs it would be appropriate for models to be produced for each sector body e.g. NHS, Unitary Authorities, Community and Town Councils etc. A mandatory model would ensure greater consistency across Wales and set a desired standard for the handling of complaints.

Question 9 – There would be little in the way of additional costs as there is already a model in place. The additional direct cost of producing variable models for each sector would be more than offset by the reduced costs incurred by each body in adapting their own.

OMBUDSMAN'S JURISDICTION.

Question 10 – In general terms the Ombudsman's jurisdiction is about right. However, where there are overlapping elements into private healthcare or private nursing homes it is fundamentally wrong to restrict the extent of an investigation which is frustrating to both the investigator but more importantly to the aggrieved.

Question 11 – One Voice Wales would support the proposed extension of the Ombudsman's role.

Question 12 – Perhaps charging could be on the basis of a charge per case based on time spent on the investigation which would not be applied if the performance of the private provider was found to be acceptable.

Question 13 – No comments.

LINKS WITH THE COURTS.

Question 14 – One Voice Wales considers that it would be important to provide the complainant with the choice. This would help resolve the matter without the costs and individual pressure that Courts processes can entail.

Question 15 – One Voice Wales has no particular strong view on this though accepts that having this recourse may be appropriate in specific cases so would not be averse to such a development.

Question 16 – No comments.

OTHER ISSUES.

Question 17 – No comments.

Question 18 – There is a need to amend to reflect the formation of Natural Resources Wales.

Question 19 – One Voice Wales would suggest 'after 5 years.'

Question 20 – There is a possibility that there could be an escalation in complaints received and some of these might be lightweight or inappropriate.

Question 21 – No comments.

Question 22 –

Jurisdiction – No comment

Recommendations and Findings – They should be binding subject to appropriate appeal arrangements being in place.

Protecting the Title – One Voice Wales agrees that the PSOW should give approval to use of titles by others.

Code of Conduct Complaints – It is considered important that the PSOW retains his current remit for our sector where internal resolution arrangements are not in place.

Question 23 – No comment.

Question 24 – No comment.

Archwilydd Cyffredinol Cymru
Auditor General for Wales

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Ms Jocelyn Davies AM
Chair, Finance Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Date: 19 February 2015
Our ref: HVT/2271/fgb

Dear Jocelyn

INQUIRY INTO THE CONSIDERATION OF POWERS: PUBLIC SERVICES OMBUDSMAN FOR WALES

Thank you for your letter of 26 January 2015.

My views on the particular issues you raise are as follows. My answers to your general (Annex A) consultation questions are attached in the Annex.

(i) Whether given my role in overseeing the Welsh Consolidated Fund there would be any significant financial issues arising from the Ombudsman's proposals should a Bill be introduced, particularly in relation to Standing Order 26.6 (viii)?

In terms of Standing Order 26.6 (viii), I do not think it should be necessary or likely for the proposals put forward by the Ombudsman to require provision to be made for charging directly on the Fund. As you know, direct charge provisions enable funds to be paid without further Assembly approval (in the form of budget motions), and are appropriate for enabling certainty of payment, such as for indemnities and salaries of constitutionally significant offices (such as that of the Presiding Officer). The Ombudsman's proposals do not seem to relate to that kind of matter. One of the five areas put forward is termed "Complaints Standards Authority", but I understand that this is intended to be a brand for the proposed model complaints policy work, rather than a proposal for a new public body that might require provision for direct charges.

My further views on the wider financial implications of the Ombudsman's proposals are in my answers to your Annex A consultation questions (please see Annex to this letter).

(ii) Whether I have any concerns that 'own-initiative' investigations by the Ombudsman could conflict with the Auditor General's value for money investigations. How could this risk be managed?

I think that there is a possibility of overlap with my value for money studies, but I do not think it would be a great risk. Furthermore, I think that risk could be managed effectively fairly easily. I am sure that both the Ombudsman and I would in any case continue to confer with one another regarding our respective forward programmes. To put the matter

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beyond doubt, however, it would be appropriate to include provision in legislation requiring the Ombudsman and the Auditor General each to take account of the other's views before exercising the relevant functions and to co-operate with one another in so far as they consider is necessary for the effective exercise of those functions.

(iii) *Is there a need for a co-ordination role between the Auditor General for Wales, the Ombudsman and independent commissioners to help their investigations and recommendations to improve public services?*

I think the requirements that I suggest in response to question (ii) would provide appropriate co-ordination. I do not think that further co-ordination provision, such as specific co-ordination role to be held by any particular person should be necessary.

(iv) *Would the proposed reforms of the Ombudsman's role be better carried out in advance of wider public sector reforms, or after?*

For the most part, I do not think that there are strong timing issues either way. However, I do think that it would be somewhat more economical and efficient to introduce a requirement on public bodies to adopt model complaints policies at the same time as establishing complaints policies for merged bodies than either introducing such requirements before or after mergers. Such timing should help bodies to avoid having to make two sets of changes to their complaints procedures.

I should be happy to provide further explanation if the Committee would find that helpful.

Yours sincerely

HUW VAUGHAN THOMAS
AUDITOR GENERAL FOR WALES

Enc: *Annex A: Responses to Annex Consultation Questions*

Annex A

RESPONSES TO ANNEX CONSULTATION QUESTIONS

1. *What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?*

On the basis of our monitoring of issues arising from the audit of accounts and wider monitoring for the purposes of planning value for money studies, I have no particular concerns regarding lack of effectiveness of the current legislation.

Own initiative investigations

2. *Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on 'own initiative' investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.*

I consider that own initiative investigations would enable wider systemic problems to be addressed coherently. I also think that such a power should enable evidently problematic matters to be investigated despite the absence of complaints, which might, for example, be the case with systemic problems that affect particular groups who tend to be reluctant or unable to raise complaints.

I consider that such a power to undertake such investigations should be used sparingly, but I think it is very likely that resource constraints and oversight of resourcing by the Assembly will ensure that the power is not used excessively.

3. *Do you have any concerns that own-initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?*

I think that there is a possibility of overlap with my value for money studies, and perhaps with inspections by the Welsh Ministers (HIW and CSSIW) and Estyn. But I think the risk could be managed effectively fairly easily. As I say in my covering letter, I am sure that both the Ombudsman and I would in any case continue to confer with one another regarding our respective forward programmes. To put the matter beyond doubt, however, it would be appropriate to include provision in legislation requiring the Ombudsman and the Auditor General each to take account of the other's views before exercising the relevant functions and to co-operate with one another in so far as they consider is necessary for the effective exercise of those functions.

4. *Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?*

The cost estimate provided in the Ombudsman's proposal paper are realistic in respect of sparing use of own-initiative investigation powers—say one or two investigations each year. In terms of benefits, it is not possible to predict the likely monetary benefits of such powers. I would hope that good use of such powers would lead to reduced levels of

maladministration leading to efficiency savings as well as increased public satisfaction (and reduced harm and distress to individuals), but such benefits are very difficult to quantify, let alone predict.

Oral complaints

5. *At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.*

As I understand it, it is not actually the case that the Ombudsman can only accept complaints in writing. Section 2(4) of the Public Services Ombudsman (Wales) Act 2005 provides the Ombudsman with discretion to investigate oral complaints, and I gather that the Ombudsman does indeed investigate such complaints. I do, however, also understand that Ombudsman's office time is taken up in writing up oral complaints and seeking confirmation that the complainant wishes the Ombudsman to proceed with investigation. I am not sure what the most appropriate solution to that problem is; I am not sure that removing the requirement in section 5 of the 2005 Act for complaints to be made in writing would, on its own, make much difference, given the discretion to investigate complaints that do not meet section 5. I do suspect, however, that new provision for own-initiative investigations should help the Ombudsman address serious issues that have been raised orally but not confirmed.

6. *What other type/form of submission should be acceptable (eg email, website form, text messages)*

As I understand it, email, webform and text message submissions would be held by the courts to be written submissions. I do not see it should necessary for a submission to be made by letter on paper.

7. *Do you have a view on the financial costs and benefits of this provision?*

As I not sure how specific provision for oral complaints would operate, I cannot give a view on financial costs and benefits. If a solution can be found to the problem of staff time being spent on recording oral complaints that are not confirmed, then there may be some financial saving in the sense of avoiding what can be regarded as nugatory work. But I think any solution that makes it easier to submit complaints orally will also lead to more complaints, which will increase costs. I do, however, see that there may be real benefit to vulnerable people in making the submission and investigation of oral complaints easier.

Complaints handling across public services

8. *At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.*

I think this proposed development would be likely to be beneficial overall. I think there is a strong parallel with the Information Commissioner providing clear guidance to

public bodies on review procedures for FOI, which helped eliminate some very unhelpful practices in some bodies. The required adoption of model policies should enable good and efficient complaints handling practice to be embedded across public bodies. This should be conducive to improved effectiveness (better handling).

It may helpful to provide for the Ombudsman to be able to approve deviation from a model policy, such as where the requirements of a body's operations do not fit well with the model policy. There may also be a need to exempt certain matters from the model policy, such as FOI review procedures, as those are subject to other regulation.

9. Do you have a view on the financial costs and benefits of this provision?

While the overall net savings are not likely to be great and will be hard to quantify, particularly where complaint handling staff do not work with a time recording system, I think the required adoption of model policies should be conducive to improved economy by, among other things, saving bodies spending time and money on devising their own policies. Similarly some savings might be achieved where public bodies are operating poorly designed policies.

Ombudsman's jurisdiction

10. What are your general views on the Ombudsman's current jurisdiction?

Generally, I think the Ombudsman's current jurisdiction is appropriate.

11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?

I can see merit in a "follow the citizen" approach, where private healthcare is received in conjunction with public healthcare. I do, however, see defining linkages in care histories as possibly quite challenging in some cases. And there may be other issues in defining the scope of healthcare to be covered by the Ombudsman's jurisdiction. There are, however, also wider public policy issues on which I do not think it is appropriate for me to comment.

12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)

These are public policy issues on which it is probably not appropriate for me to comment.

13. Do you have a view on the financial costs and benefits of this provision?

Again, I am not in a position to comment.

Links with the courts

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (ie this would give complainants the opportunity to decide which route is most appropriate for them.)

Given the potential additional cost to the public purse, I would be concerned if the removal of the statutory bar meant that complainants had not just a choice of remedy (ie one or the other) but two remedies to pursue. Furthermore, as the statutory bar does not apply if the Ombudsman is satisfied that in the particular circumstances it is not reasonable to expect the person to resort to the right remedy, I am not sure that there is a pressing case for the removal of the statutory bar in terms of removing impediments to remedy for vulnerable people.

15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?

In principle, referral of cases to the Courts for the determination of points of law seems sensible, but there is need for consideration of who should bear the cost of such referrals.

16. Do you have a view on the financial costs and benefits of this provision?

My answers to questions 14 and 15 indicate my concerns as to the costs of such changes.

Other issues

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

No, but that is not to say that I do not see an own initiative investigation and model complaints policy functions as not having benefits.

18. Schedule 3 of the current 2005 Act, provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

I am not aware of any significant omissions from the list.

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

A baseline review before commencement would be helpful. Thereafter, given the timescales for undertaking and allowing the effects of own-initiative investigations and model complaints policy work, evaluation at least three to five years after commencement would be appropriate if the evaluation is to address effectiveness. However, if the evaluation were confined to assessing whether the provisions were fit for purpose in terms of enabling the processes to commence (which is quite a narrow focus), then it could be undertaken one to two years after commencement.

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

While mentioned above, I would say again that there may be unintended cost consequences of specific provision for oral complaints. Similarly, there may be unintended cost consequences of removal of the statutory bar on matters that could be considered by the Courts.

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

I would need to undertake some extended research in order to answer this properly.

22. Do you have any comments on the following issues:

- *areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;*

Such consideration would be appropriate for any new service-delivery organisations, but probably not for new review bodies (eg the forthcoming Future Generations Commissioner).

- *recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;*

In my view, binding recommendations could be problematic. They may confuse or reduce the accountability of the executives of public bodies. The existing provisions in the Act for reporting and certifying non-action seem appropriate.

- *protecting the title - there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;*

This seems to me to be a sensible precaution against misuse. Regulations already exist to provide such protection for titles such as "government" and "auditor general" (it may be appropriate to ask for an insertion into Schedule 4 of the *Company, Limited Liability Partnership and Business (Names and Trading Disclosures) Regulations 2015*).

- *code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils' resolutions. Whilst a local resolution procedures exists and has been adopted by 22 local authorities, variance exists in practice.*

I can see the merits of that preference, but I consider that there is a need for investigation of serious code of conduct complaints.

23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

I think it is likely that the proposed public sector reforms and continuing austerity will increase the volume of the Ombudsman's casework, at least in the short to medium term—separating the effect of the proposed reforms and the effect of austerity may be difficult. Similarly, the proposed public sector reforms and continuing austerity will increase the volume of complaints to public bodies. This latter point may reinforce the case for Ombudsman having model complaints policy functions.

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

Not at present.

19 February 2015

WLGA Evidence

Finance Committee Inquiry: Consideration of powers: Public Services Ombudsman for Wales

February 2015

The WLGA welcomes the opportunity to present evidence to the Committee on its inquiry into the consideration of powers for the Public Services Ombudsman.

The WLGA is aware that this inquiry could potentially lead to new legislation concerning the Ombudsman's powers being introduced, possibly by this Committee, before the end of this Assembly term. Clearly the Committee must conclude its Inquiry, which may or may not lead to proposals to introduce legislation as a result.

The WLGA notes however that a Committee Inquiry which led to the introduction of a significant new piece of legislation could mean a curtailed process around policy review and legislative scrutiny given it is our understanding that a Committee Bill would automatically bypass the Stage 1 Committee process. If this is the case, there would be reduced scope for effective consultation and engagement with the general public and public bodies affected by policy proposals and legislation.

The WLGA therefore would request that should the Committee decide to move to legislation, that a Draft Bill is published to encourage the widest opportunity for consultation before the formal introduction of the Bill.

1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

The Act is generally regarded as effective. As noted by the Ombudsman's own submission to the Committee, the Law Commission commented favourably on the Act but put forward a number of proposed amendments to clarify and improve the Ombudsman's role.

Own initiative investigations

2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on 'own initiative' investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.
3. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

4. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

The WLGA recognises the Ombudsman's frustration where his current powers prevent him from exploring suspected wider concerns within public services stemming from an investigation into an initial individual complaint. The WLGA however shares the Welsh Government's concerns over the risks of 'mission-creep' (as stated in a letter to the Communities, Equalities and Local Government Committee from Minister for Local Government and Government Business on 12th February 2014). In principle, it is of course appropriate that such concerns over wider and potentially systemic public service issues should be investigated, however there are a number of investigatory bodies whose role it is to examine matters of governance or public service concerns or improvements. There would be scope for duplication between the Ombudsman and these existing bodies, such as the Auditor General for Wales, as well as potential burden for public service bodies.

Whilst the Welsh Government notes that any such new powers should be carefully circumscribed and available in specific and exceptional circumstances, an alternative model could be that where the Ombudsman has identified wider systemic concerns following an initial investigation into a complaint, he then writes to the Auditor General for Wales (or relevant inspectorate) advising him/her to undertake a special inspection or produce a Public Interest Report into the matter.

Oral Complaints

5. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.
6. What other type/form of submission should be acceptable (e.g. email, website form, text messages)
7. Do you have a view on the financial costs and benefits of this provision?

The WLGA agrees that alternative arrangements for submitting complaints should be considered to ensure that the Ombudsman is accessible to all. Oral complaints should be acceptable, but such safeguards and procedures will be need to be introduced to ensure such complaints can provide consistency in terms of detail, as well being recorded and stored securely and confidentially.

The financial costs and/or benefits of any such provision would depend on digital solutions, any necessary additional administrative support and the volume of oral complaints received.

Complaints handling across public services

8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh

government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.
9. Do you have a view on the financial costs and benefits of this provision?

The WLGA supported the Ombudsman in the development of the model complaints policy which was published in 2011[1]. The WLGA understands that 21 of the 22 authorities have implemented the model policy and 1 is reviewing its complaints procedures in line with the model. It is likely that the anticipated mergers of local authorities would see further streamlining and consistency of complaints processes within local government.

Ombudsman's jurisdiction

10. What are your general views on the Ombudsman's current jurisdiction?
11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?
12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)
13. Do you have a view on the financial costs and benefits of this provision?

The WLGA does not have strong views regarding the Ombudsman's jurisdiction or powers in private healthcare, although the case put forward in the Ombudsman's paper appears compelling.

Links with the courts

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (ie this would give complainants the opportunity to decide which route is most appropriate for them.)
15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?
16. Do you have a view on the financial costs and benefits of this provision?

[1] http://www.ombudsman-wales.org.uk/~/media/Files/Documents_en/Model%20Complaints%20Policy%20Final%20PSOW.ashx

The WLGA recognises the Ombudsman's rationale for removing the statutory bar with a view to improving the public's accessibility to resolution of complaints. That said, this is the most significant legislative and jurisdictional reform that the Ombudsman proposes which would have implications for law across England and Wales and a potentially significant impact in terms of workload and resources for the Ombudsman. It is unclear what data is available or what analysis has been undertaken to assess the impact of such a reform or the Assembly's competence in this arena given the territorial jurisdiction of the courts. The WLGA also notes that in his oral evidence, the Ombudsman suggested that of his 5 proposed areas for reform, removal of the statutory bar (given the above complexity) was not the highest priority reform.

Other issues

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

No.

18. Schedule 3 of the current 2005 Act, provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

The list in Schedule 3 appears appropriate, although it should be updated to incorporate bodies established or renamed after the 2005 Act.

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

As the Ombudsman noted in his oral evidence to the Committee, there is significant and ongoing reform of public services and the devolution settlement and there would probably not be an 'ideal time' to take stock. That said, the current timeframe of ten years for reviewing the current Public Services Ombudsman (Wales) Act 2005 is probably too long given the anticipated changes to public services and a five year review would probably be more appropriate.

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

As noted above, the main concern regarding unintended consequences is the potential for jurisdiction between the Ombudsman and the Auditor General for Wales around 'self-initiative' investigations. This could be mitigated by clear criteria for

such investigations, agreement of protocols between inspection bodies or a process by which the Ombudsmen requests that other bodies carries out follow-up inspections or investigations after his initial work.

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

It is difficult to determine an appropriate cost-benefit analysis given limited data has been presented to date which could be used to assess the likely impact in terms of additional complaints and, subsequently, upheld complaints as a result of any legislative changes. Should this Inquiry lead to legislation, a more thorough Regulatory Impact Assessment should be completed which should assess the potential impact, particularly in terms of workload on the Ombudsman's office and public services as a result. In principle however, it is difficult to quantify the value of a regulatory or complaints regime which seeks to provide assurance and public confidence about public services, provides support and redress to individuals who have had a complaint upheld and contributes to wider service improvements.

22. Do you have any comments on the following issues:

- **jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;**
  See 18 above

- **recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;**

  The current approach to Ombudsman recommendations works effectively in Wales. The relationship between the Ombudsman and public services is based on early, open and constructive dialogue, where 'quick fixes' are encouraged. The regulatory relationship would shift significantly if recommendations were made to be binding, with implications for local democratic discretion and/or challenge or appeal.

- **protecting the title - there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;**

  The WLGA does not have strong views on this matter.

- **code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service**

delivery, rather than local authority and town and community councils' resolutions. Whilst a local resolution procedures exists and has been adopted by 22 local authorities, variance exists in practice.

Local resolution procedures have been developed by local authorities, the WLGA and the Ombudsman and they are increasingly effective in managing lower level complaints about the conduct of councillors. These procedures have meant a reduced burden on the Ombudsman's office, but in turn has meant a transfer of workload (but not of resources) to local authorities. The Ombudsman's latest Annual Report shows that code of conduct complaints were down 22% in 2013-14 at 228 new complaints, of which only 111 related to county or county borough councils. Of the 228 complaints, only 41 were investigated and only 6 investigation reports led to referral to either a standards committee or the Adjudication Panel for Wales.

The Ombudsman was specifically established to investigate complaints about councillors' conduct as well as complaints about public services. Although the Ombudsman's own workload and priorities have varied during recent years, his role in independently investigating complaints about councillors' conduct remains a vital back-stop role which local government would wish to retain, particularly for most serious breaches of the code of conduct.

It is not possible to meaningfully enforce a code of conduct for councillors without an independent statutorily empowered investigative and adjudicator framework. Such a reform of the Ombudsman's role and weakening of the code would be a retrograde step at a time when so much controversial reform is proposed within local government.

23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

See preamble above.

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

No

	Complaints Section of website	Methods of receiving complaint	Are complaints reports presented to members?
1. Blaenau Gwent	http://www.blaenau-gwent.gov.uk/council/149.asp	• Phone, email, letter and text. • Children or young people offered a 'Freephone Buddy' service.	• The Ombudsman's Annual Letter is considered by Audit Committee • Corporate Overview Committee receives complaints information in quarterly Joint Finance & Performance Report
2. Bridgend	http://www1.bridgend.gov.uk/services/concerns-and-complaints-policy.aspx	• Phone, email, letter and webform.	• The Ombudsman's Annual Letter is considered by Standards Committee, including the Ombudsman's Casebook. https://democratic.bridgend.gov.uk/ieListDocuments.aspx?CId=133&MID=1489#AI529 • Annual Complaints Reports are presented to Cabinet. ○ https://democratic.bridgend.gov.uk/documents/s1317/140722%201%20Corporate%20Complaints%20Policy.pdf ○ https://democratic.bridgend.gov.uk/documents/s1318/140722%201%20Corporate%20Complaints%20Policy%20Appendix.pdf
3. Caerphilly	http://www.caerphilly.gov.uk/My-Council/Complaints-and-feedback	• Phone, email, letter and webform.	• The Ombudsman's Annual Letter is presented to Standards Committee and full Council • Reports detailing complaints under the council's corporate complaints policy are reported to Audit Committee on a six monthly basis.
4. Cardiff	https://www.cardiff.gov.uk/ENG/Home/Contact-us/Comments-complaints-and-compliments/Pages/default.aspx	• Phone, face-to-face at offices/hubs, email, letter and webform. • Contact local councillor	• Annual Complaints Report presented to Cabinet - https://formerly.cardiff.gov.uk/objview.asp?object_id=29638 • Quarterly Performance Reports include complaints information – these are reported to Cabinet and Policy Review and Performance Scrutiny Committees

5. Carmarthenshire	http://www.carmarthenshire.gov.uk/English/council/complaints/Pages/Home.aspx	• Phone, email, letter and webform.	• The Ombudsman's Annual Report is taken to Standards Committee annually. • Statistics on our internal complaints, and Ombudsman's complaints are taken to Scrutiny Committee quarterly by the Complaints Team. • S. 16 reports are reported to Full Council when issued.
6. Ceredigion	http://www.ceredigion.gov.uk/English/Your-Council/Complaints/Pages/Complaints-Policy.aspx	• Phone, email, letter and webform. • Contact local councillor	• Annual Complaints Report presented to full Council - http://www.ceredigion.gov.uk/cpdl/Democratic_Services_Meetings_Public/H%2020140925.pdf
7. Conwy	http://www.conwy.gov.uk/doc.asp?cat=5239&doc=19880	• Phone, email, letter and webform.	• The Ombudsman's Annual Letter/Annual Report is considered by Cabinet and Scrutiny. • As from 01/04/2014 analysis of lessons learned from service complaints will be produced in the annual report presented to scrutiny and cabinet.
8. Denbighshire	https://www.denbighshire.gov.uk/en/your-council/complaints-compliments-and-feedback/complaints-compliments-and-feedback.aspx	• Phone, letter and webform.	• A Your Voice annual report presented to Corporate Governance Committee – this includes a summary of the Ombudman's annual report and letter and also contains the Council's investigation summaries. https://moderngov.denbighshire.gov.uk/ieListDocuments.aspx?CId=130&MId=4902&Ver=4&LLL=0 • Performance Scrutiny Committee receive complaints reports on a monthly basis. The report contains information on numbers of complaints and timescale adherence. Using these reports, Members identify areas which require more detailed analysis and this is provided on a quarterly basis. https://moderngov.denbighshire.gov.uk/ieListDocuments.aspx?CId=269&MId=4996&Ver=4&LLL=0

9. Flintshire	http://www.flintshire.gov.uk/en/Resident/Contact-Us/Compliments-Concerns-and-Complaints.aspx	• Phone, email, letter and webform.	• Ombudsman's Annual Letter presented to Cabinet and the Standards Committee http://cyfarfodyddpwyllgor.sirysfflint.gov.uk/ieListDocuments.aspx?CId=152&MId=3229&Ver=4&LLL=undefined
10. Gwynedd	https://www.gwynedd.gov.uk/en/Council/Contact-us/Formal-complaint.aspx	• Phone, Face-to-face, letter and webform.	• The relevant Cabinet Member and Corporate Management Team will receive regular reports on the type of complaints received and the lessons to be learnt. • An annual report on complaints will also be prepared summarising the lessons learnt and how they have contributed to service improvement.
11. Merthyr Tydfil	http://www.merthyr.gov.uk/english/councilanddemocracy/complaints/pages/complaintsprocedure.aspx	• Phone, email, letter and webform.	• Cabinet members are informed of significant complaints relating to their area and are involved in discussions about outcomes where a complaint is upheld. Also if there is a complaint which is upheld and where a sanction is imposed that is reported to Cabinet.
12. Monmouthshire	http://www.monmouthshire.gov.uk/feedback	• Phone, email, letter and webform.	• Ombudsman's Annual Letter presented to Standards Committee • Annual reports on complaints are presented to Audit Committee ○ http://www.monmouthshire.gov.uk/events/event/audit-committee-9 • Annual reports on Social Services complaints are presented to Adults Select and Children's Select Committee
13. Neath Port Talbot	http://www.npt.gov.uk/defa	• Phone, face-to-face	• Ombudsman's Annual Letter and Annual Council Update Report on

	ult.aspx?page=2777	at contact centre, email, letter and webform.	complaints is presented to Policy and Resources Cabinet Board • Annual Council Update Report on complaints is presented to Policy and Resources Overview and Scrutiny Committee ○ https://democracy.npt.gov.uk/documents/g758/Public%20reports%20pack%2004th-Sep-2014%2012.00%20Policy%20and%20Resources%20Cabinet%20Board.pdf?T=10 ○ https://democracy.npt.gov.uk/documents/s5233/Customer%20Services%20Contact%20Centre%20Performance.pdf ○ https://democracy.npt.gov.uk/documents/s5402/Complaints%20Compliments%20and%20Comments%20-%20Annual%20Report.pdf • Ombudsman's Annual Report presented to Standards Committee (code of conduct complaints)
14. Newport	http://www.newport.gov.uk/_dc/index.cfm?fuseaction=council.homepage&contentid=n_058334	• Phone, email, letter and webform.	• Ombudsman's Annual Letter and Annual Council Update Report on complaints is presented to Standards Committee • The data from the Ombudsman's Letter is included within the annual Report to Cabinet on the number of corporate and social services complaints (and compliments) received, the outcomes and an analysis of the lessons learnt. • In accordance with the Council's Performance Management Framework, the Service Improvement Plans for each service area also contain details of the complaints and compliments received, and these are reported to the relevant Scrutiny Committee on a 6 monthly basis.
15. Pembrokeshire	http://www.pembrokeshire.gov.uk/content.asp?nav=101,1039	• Phone, email, letter and face-to-face.	• The Council's Standards Committee considers the Annual Report by the PSOW (usually at its meeting in the autumn - http://vmmoderngov1:8070/ieListDocuments.aspx?CId=304&MId=3213&Ver=4&LLL=0) and undertakes an analysis of the complaints received by the Council in particular. • Half yearly reports on complaint handling is provided to

			Cabinet. The Cabinet and Overview and Scrutiny Committees dealing with children and adult care receive the annual Social Services Complaints report - http://vmmoderngov1:8070/ieListDocuments.aspx?CId=281&MId=3155&Ver=4&LLL=0 .
16. Powys	http://www.powys.gov.uk/en/customer-services/make-a-complaint/	• Phone, email, letter and webform.	• Ombudsman's Annual Report is presented to Standards Committee with a link to the PSOW website for access to individual reports. • The existence and outcome of active individual reports are notified to each Standards Committee. Details of the complaint and the identity of the accused is not given • PSOW casebook is also taken to Standards Committee
17. Rhondda Cynon Taf	http://www.rctcbc.gov.uk/en/councildemocracy/corporatecomplaints/complaints-procedure/complaintsprocedure.aspx	• Phone, face-to-face, email, letter and webform.	• Ombudsman's Annual Letter is presented to the Corporate Services Scrutiny Committee - http://www.rctcbc.gov.uk/en/councildemocracy/democracyelections/councillorscommittees/meetings/corporateservicesscrutinycommittee/2014/09/11/reports/item4-complaintsofmaladministration.pdf • The use of the Council's 'Unreasonably Persistent Customer Policy' is reviewed annually by the Council's Standards Committee. • Scrutiny committees can request analysis/updates/reports on service complaints received.
18. Swansea	https://www.swansea.gov.uk/complaints	• Phone, face-to-face, email, letter and webform.	• Ombudsman's Annual Report is presented to Standards Committee • An Annual Corporate Complaints Report goes to Cabinet, incorporating the Social Services Annual Reports for Children Services & Adult Services -

			○ http://democracy.swansea.gov.uk/ieListDocuments.aspx?CId=124&MId=5575&Ver=4&LLL=-1
19. Torfaen	http://www.torfaen.gov.uk/lgsl/en/Complaints/Complaints/How-to-Complain.aspx	• Phone, email, letter and webform.	• Resources Overview and Scrutiny Committee receive complaints received in the Resources Directorate. • Social care complaints are reported to the relevant Executive Member
20. Vale of Glamorgan	http://www.valeofglamorgan.gov.uk/en/our_council/complaints_and_compliments.aspx	• Phone, face-to-face, email, letter and webform.	• Ombudsman's Annual Letter a is presented to Cabinet • Annual Complaints Report presented to Cabinet
21. Wrexham	https://www.wrexham.gov.uk/top_navigation/complaints/introduction.htm	• Phone, face-to-face, email, letter and webform.	• Ombudsman's Annual Letter presented to Executive Board • 6 monthly complaints reports presented to Customers, Performance & Scrutiny Committee ○ http://moderngov.wrexham.gov.uk/ieListDocuments.aspx?CId=138&MID=2558#AI1271&LLL=undefined ○ http://moderngov.wrexham.gov.uk/ieListDocuments.aspx?CId=138&MID=2549&LLL=undefined • Ombudsman's Annual Report presented to Standards Committee
22. Ynys Mon	http://www.anglesey.gov.uk/make-an-official-complaint/102251.article	• Phone, email, letter and webform.	• Ombudsman's annual letter/annual report presented to Audit Committee • Anonymised complaints data is reported on the Council website with the information updated monthly. Trend analysis forms part of the annual report to the Audit Committee.

FINANCE COMMITTEE OF THE NATIONAL ASSEMBLY FOR WALES

INQUIRY INTO THE POWERS OF THE PUBLIC SERVICES OMBUDSMAN FOR WALES

CONSULTATION RESPONSE

DR NICK O'BRIEN

BACKGROUND

1. The views expressed below are mine alone. I have limited my comments to those issues on which I am competent to express an informed view.

2. In 2013-14 I served as Specialist Adviser to the House of Commons Public Administration Select Committee (PASC) inquiries into complaints about public services and into the future of the UK Parliamentary Ombudsman and Health Service Ombudsman for England (PHSO).

3. I had previously held posts as Director of Policy and Public Affairs, and Legal Policy Adviser, at the office of the PHSO (2007-2012); as Legal Director at the GB Disability Rights Commission (2000-2007); and as Legal Adviser, and then Deputy Ombudsman, at the Office of the Legal Services Ombudsman for England and Wales (1991-2000). I am an honorary research fellow in the Law School at Liverpool University and have written widely about ombudsmen, as well as about disability rights and human rights more generally.

GENERAL COMMENTS

4. I support without reservation the proposed changes in respect of own initiative investigations, oral complaints, complaints handling across public services, and links with the courts. I have reservations (explained below) about the proposed extension of the Ombudsman's jurisdiction to self-funded private healthcare but nevertheless support it. Although the PSOW Act is already among the more developed examples of public-sector ombudsman legislation, the reforms suggested would otherwise strengthen the Ombudsman's role and improve access and impact.

5. In respect of the other issues referred to in the Consultation Paper, I support the inclusion of other bodies within the Ombudsman's jurisdiction, the exclusion from jurisdiction of code of conduct complaints and the protection of the title of Ombudsman, but I have reservations about making the Ombudsman's recommendations (as opposed to the Ombudsman's findings) binding.

6. More generally, I am mindful of the potential, albeit indirect, impact on the Ombudsman of the EU ADR Directive, of the changing landscape for the delivery of

public services within the UK, and of the increasingly uncertain boundaries between the public and private sector. These factors make the consideration of legislative reform especially timely and necessary.

EFFECTIVENESS OF THE CURRENT PSOW ACT 2005

7. The 2005 Act has proved to be broadly effective, enabling the PSOW to establish itself as a modern public services ombudsman, with the ability to provide good access to the public, to resolve disputes swiftly and effectively, and to provide remedies that deliver both individual redress and systemic reform in the public sector.

8. As a result the PSOW commands the respect of citizens and public bodies in Wales, and in the ombudsman community throughout the UK.

9. The ADR and public-service delivery environment is, however, in flux. In common with other public sector ombudsmen, the PSOW faces new challenges as a result. The review and reform of the statutory remit is therefore an essential condition of meeting that challenge successfully.

OWN INITIATIVE INVESTIGATIONS

10. The vast majority of national ombudsman institutions throughout Europe, and indeed throughout the world, have own initiative powers. Such powers enable an ombudsman to investigate in the public interest even if an individual complaint has not been made. As such they have the potential to extend the reach and strategic impact of the ombudsman.

11. More than any other available innovation, the introduction of own initiative powers would enable the Ombudsman to hold the Executive to account, to address the real concerns of citizens, especially the most marginalised, and to provide systemic remedy that might beneficially transform the delivery of public services and the discharge of public functions in Wales.

12. In particular, own initiative powers can be used in situations where there is widespread and reasonable grounds for suspecting significant injustice but where credible individual complaints are not forthcoming, for example because those experiencing such injustice are especially marginalised, or because the scale of the injustice perpetrated is not apparent to any one individual but is more easily detected from a wider collective perspective.

13. Such powers have been widely and effectively used in Europe, for example by the ombudsmen in Austria, Sweden and Finland, and further afield by the ombudsmen in Australia and Canada at both national and state level.

14. In Northern Ireland the Ombudsman is in the process of acquiring an own initiative power as a result of legislative reform, and in the Republic of Ireland the Ombudsman already has such a power, which has been used sparingly.

15. Last year, PASC recommended that PHSO should acquire an own initiative power of this sort.

16. Similar powers have been used successfully by other non-ombudsman institutions in the UK for a long time, for example from the 1970s by the various equality commissions (CRE, EOC and DRC) and now by the EHRC.

17. There is in principle a danger that with such powers the Ombudsman might encroach on the territory of other regulators or inspectorates, whose remit already entails proactive scrutiny. The Ombudsman would, however, be seeking to use its proactive power in a different way: it would be conducting its investigation in response to identifiable evidence of prima facie injustice, caused by maladministration, and remediable by ombudsman-style recommendation. To that extent its role would remain distinctive.

18. Careful legislative drafting, supported by memoranda of understanding between the Ombudsman and other regulators and inspectorates, would adequately manage any such encroachment that still existed, or that was perceived to exist.

19. Furthermore, the exercise of such powers would enable the Ombudsman to prevent the escalation of injustice and to investigate in a more focussed manner. To that extent, the benefits, financial and otherwise, afforded by such investigations would be compounded.

ORAL COMPLAINTS

20. The need to put complaints in writing is unnecessarily restrictive and a potential barrier to access, not least for those who are disabled or who have restricted literacy. The desire to have a record of a complaint can be met by allowing access by email, website form or text, as well as by telephone if calls are recorded or their content otherwise transcribed.

21. It is in any event arguable that failure to permit access by these alternative means would constitute a breach of equality legislation.

COMPLAINTS HANDLING ACROSS PUBLIC SERVICES

22. The Ombudsman is in a privileged position to prescribe standards for complaint handling across the public services, drawing upon the empirical experience of handling complaints in large numbers.

23. This 'design authority' function already exists in Scotland, where it has been used successfully, and was recommended by PASC for the UK Parliamentary Ombudsman.

OMBUDSMAN'S JURISDICTION

24. The distinction between public and private domain is becoming increasingly difficult to maintain. It is nevertheless a distinction that is fundamental to the function and identity of a 'public services' ombudsman. The Ombudsman's remit should therefore be limited, so far as is practicable, to the exercise of functions by those acting in the public domain and in accordance with the public interest that warrant protection other than merely by the operation of the market.

25. The ability of the Ombudsman to investigate private healthcare commissioned by the NHS could on that account be supplemented, in accordance with that notion of the public domain, by extension to self-commissioned private healthcare, at least to the extent that this is delivered in conjunction with public healthcare. Indeed, the absence of such a power can create a distinction between ombudsman coverage which is likely to make little sense to patients, so long as the Ombudsman's function is conceived (albeit mistakenly) as nothing more than that of dispute resolution for consumer complaints about quality of service.

26. Notwithstanding the pragmatic attraction of such a concession in this instance, the public-interest aspect of the Ombudsman's role is otherwise worth preserving emphatically, as a matter of principle. The democratic accountability function of the Ombudsman is fundamental to the role and should not be diluted into a form of private dispute resolution or a device for holding to account institutions whose public-interest remit is marginal and whose ethos is primarily market-oriented.

LINKS WITH THE COURTS

27. I support the removal of the statutory bar since this would increase the Ombudsman's discretion to investigate appropriately and in a manner proportionate to the issues at stake.

28. With the erosion of publicly funded legal advice and representation, theoretical access to the civil courts should no longer constitute a special category of grounds for an ombudsman to be barred from investigation. There will nevertheless be cases where the Ombudsman is not the appropriate forum and a complainant will need to be directed to seek remedy elsewhere, including through the civil justice system if so advised.

29. I do not see any objection to the Ombudsman having the power to refer cases to a court for a determination on a point of law. However, the occasions when the use of such a power is needed would be rare, since disputes that turn on a point of law are not likely to be suitable for investigation by the Ombudsman in the first place.

OTHER ISSUES

Recommendations and findings

30. I do not think the Ombudsman's recommendations should be binding. It is of the essence of the distinctive approach of an ombudsman that its mandate is one of influence rather than sanction. From this constraint flows much that is attractive about the ombudsman approach, including its relative freedom of discretion, flexibility of process and deliberative style of decision-making. Whilst there is a case for saying that a public authority is bound to accept the ombudsman's 'findings' (even in cases of ultimate disagreement) the requirement that a public authority comply with a recommendation contingent upon those findings would be seriously at odds with the authentic ombudsman ethos.

Code of conduct complaints

31. I agree that code of conduct complaints should not be within the Ombudsman's jurisdiction. The Ombudsman's chief function is the democratic holding to account of public authorities for their exercise of public functions, including (but not limited to) the provision of services to the public. That function should not be diluted by inclusion within jurisdiction of a quite distinct 'policing' function.

DR NICK O'BRIEN

20 FEBRUARY 2015

Comisiynydd Plant Cymru
Children's Commissioner for Wales
Keith Towler

Jocelyn Davies AM (Chair)
National Assembly for Wales Finance Committee
Cardiff Bay
Cardiff
CF99 1NA

19 February 2015

Dear Chair

Inquiry into the Consideration of Powers: Public Services Ombudsman for Wales

Thank you for your letter dated 9 February. Please find below our response to your specific questions. For your information, we do intend on responding to the consultation, a copy of which we'll share with you in due course.

- **Could 'own-initiative' investigations by the Ombudsman conflict with the role of independent commissioners?**

I am broadly in favour of supporting 'own initiative' investigations by the Ombudsman. However, I would wish to reinforce the need for the Ombudsman to consult with the Children's Commissioner for Wales in relation to any investigation involving a child or young person, as outlined in the current Memorandum of Understanding (MoU) between both institutions. This MoU has been established to protect the institutions' independence and I would wish to ensure that 'own initiative' investigations by the Ombudsman do not adversely impact on the scope and remit of the Children's Commissioner for Wales.

This perhaps offers an opportunity to firm up arrangements between ourselves and the Ombudsman in legislation – currently outlined in the MoU – as well as our working relationship with other similar institutions in Wales.

- **Is there a need for a co-ordination role between independent commissioners, the Ombudsman and the Auditor General for Wales to help their investigations and recommendations to improve public services?**

I already work closely with the Older Person's Commissioner, Welsh Language Commissioner and the Public Services Ombudsman for Wales and have established a Memorandum of Understanding on joint work and the sharing of information. Also established are Memoranda of Understanding with Welsh Government, Care Council for Wales and CAFCASS Cymru. I meet with the other independent commissioners and the Public Services Ombudsman for Wales on a quarterly basis. I also have meetings with the Auditor General for Wales.

Cont/d…

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It would be useful to explore further what is meant by a 'coordination role'.

- **Would the proposed reforms of the Ombudsman's role be better carried out in advance of wider public sector reforms, or after?**

We do not believe that the proposed public sector reforms have a bearing on the Public Services Ombudsman's ability to look into complaints about public services and independent care providers in Wales, although regard must be given to the financial constraints of the public sector when considering increasing the resources of the Ombudsman.

Your Inquiry into the consideration of powers of the Public Services Ombudsman for Wales coincides with my calls to strengthen the role and remit of the Children's Commissioner for Wales, discussions which I'm sure my successor and the team would be happy to pursue with you at an opportune time.

I wish you well with the Inquiry.

Yours sincerely

Keith Towler
Children's Commissioner for Wales

Meri Huws
Comisiynydd y Gymraeg
Welsh Language Commissioner

Comisiynydd y Gymraeg
Welsh Language Commissioner

Jocelyn Davies AC
Cadeirydd y Pwyllgor Cyllid
Bae Caerdydd
Caerdydd
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20/02/2015

Annwyl Jocelyn Davies AC

Ymchwiliad i Ystyried Pwerau Ombwdsmon Gwasanaethau Cyhoeddus Cymru

Diolch am eich llythyr dyddiedig 9 Chwefror yn gofyn am sylw gennyf mewn ymateb i'r ymgynghoriad uchod. Roedd eich llythyr yn gofyn i mi roi sylw i faterion penodol ond yn croesawu sylwadau pellach mewn cysylltiad â chylch gorchwyl cyffredinol yr ymchwiliad. Mae fy sylwadau fel a ganlyn:

- A allai ymchwiliadau ar ei liwt ei hun gan yr Ombwdsmon wrthdaro a rôl Comisiynwyr annibynnol?

Mae gan Gomisiynydd y Gymraeg bwerau cyfatebol i'r hyn y mae'r Ombwdsmon yn ei geisio: Gall y Comisiynydd gynnal *ymholiad*[1] i unrhyw fater sy'n ymwneud ag un neu neu ragor o'i swyddogaethau.

Ag eithrio pŵer Comisiynydd y Gymraeg i gynnal ymholiad gall y Comisiynydd hefyd gynnal *ymchwiliad* [2]i amheuaeth o fethiant sefydliad i gadw at ymrwymiadau mewn cynllun iaith Gymraeg. Daw pwerau ymchwilio cyffelyb i rym yn achos Safonau'r Gymraeg ynghyd a'r gallu i orfodi a chosbi methiannau.

[1] Adran 7, Mesur y Gymraeg (Cymru) 2011 a hefyd Atodlen 2.
[2] Adran 17 Deddf yr Iaith Gymraeg 1993 a hefyd Adran 71 Mesur y Gymraeg (Cymru) 2011.

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Correspondence welcomed in Welsh and English

Comisiynydd y Gymraeg
Welsh Language Commissioner

Caiff y Comisiynydd hefyd wneud ymchwiliad safonau[3], gwaith ymchwil, llunio a chyhoeddi adroddiadau[4].

Y pŵer tebycaf i'r "ymchwiliadau ar ei liwt ei hun" yw gallu'r Comisiynydd i gynnal ymholiad. Yn y cyswllt hwn fodd bynnag mae'n bwysig egluro nad oes modd cynnal ymholiad os oes amheuaeth o fethiant i gydymffurfio â safon(au). Nid oes modd cynnal ymholiad yn hytrach na gwneud ymchwiliad i ymyrraeth i ryddid unigolion i gyfathrebu yn Gymraeg ac ati. Os bydd y Comisiynydd wedi cychwyn ymholiad ac yn dechrau amau methiant mae sawl cam ar agor i'r Comisiynydd ar y pwynt hwnnw fel nad oes unrhyw wrthdaro rhwng gwahanol swyddogaethau o eiddo'r Comisiynydd. Mae'r Comisiynydd wedi cynnal un ymholiad ers ei sefydlu[5]. Gwaned hynny o fewn cylch gorchwyl Mesur y Gymraeg a heb dramgwyddo â rôl unrhyw barti arall.

Gellir cydymdeimlo gyda sefyllfa lle nad yw'r Ombwdsmon yn abl i fynd at wraidd achosion o fethiant y bu i unigolyn gwyno wrtho amdanynt. Bu cynnal ymholiad i brofiadau iaith Gymraeg defnyddwyr yn y maes gofal sylfaenol yn fodd o alluogi'r Comisiynydd i fynd i'r afael â phroblemau dyrys a systemig mewn perthynas â darparu gofal cyfrwng Cymraeg mewn modd na fyddai ymchwilio i achosion unigol wedi ei ganiatáu.

Mae'r Comisiynydd o'r farn y dylid rhoi ystyriaeth ofalus i ganiatáu ymestyn *ymchwiliad* ar sail methiant un sefydliad i fod yn ymchwiliad ehangach a mwy cyffredinol. Er mwyn sicrhau tegwch byddai angen tystiolaeth digonol o fethiant systemig cyn gwneud ymchwiliad neu ymestyn ymchwiliad i fwy nag un achos.

Efallai y byddai'n fanteisiol i'r Pwyllgor gymryd golwg ar adran 7 Mesur y Gymraeg a'r terfynau sy'n cael eu gosod yno ar gyfer gwneud ymholiad.

- A oes angen rôl gydlynu rhwng comisiynwyr annibynnol, yr Ombwdsmon ac Archwilydd Cyffredinol Cymru i gynorthwyo i sicrhau bod eu hymchwiliadau a'u hargymhellion yn gwella gwasanaethau cyhoeddus?

Mae adrannau 20 – 22 Mesur y Gymraeg yn creu cyfleuster i Gomisiynydd y Gymraeg gydweithio gydag amrediad o sefydliadau o dan delerau'r Mesur. Rhoddir sylw neilltuol i'r Ombwdsmon a chomisiynwyr ond nid yw cyfleuster y Mesur yn cyfyngu'r egwyddor i'r partïon hynny ac fe all Gweinidogion Cymru greu gorchymyn i ehangu cwmpas y rhai y gellir cydweithio â hwy. Mae Comisiynydd y Gymraeg wedi gohebu gyda'r Prif Weinidog

[3] Adran 61, Mesur y Gymraeg (Cymru) 2011.
[4] Adran 4, Mesur y Gymraeg (Cymru) 2011
[5] Fy iaith, Fy iechyd: Ymholiad i'r Gymraeg mewn Gofal Sylfaenol

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Welsh Language Commissioner

yn gofyn i'r Llywodraeth ychwanegu Archwilydd Cyffredinol Cymru a Swyddfa Archwilio Cymru at y teulu o sefydliadau y gall Comisiynydd y Gymraeg ymwneud â hwy.

O dan ddarpariaethau Mesur y Gymraeg mae modd cydweithio: wrth gynnal ymchwiliad, drwy gynnal ymchwiliad ar y cyd neu gyhoeddi adroddiad ar y cyd. Mae cyfeiriadau at rannu gwybodaeth o dan yr adrannau hyn ac at ddatgelu gwybodaeth.

Dylid cymryd sylw o'r ffaith y dywed Mesur y Gymraeg mai disgresiwn Comisiynydd y Gymraeg sy'n sail dros benderfynu cydweithio. Fel corfforaeth un-dyn byddai unrhyw benderfyniad i gydweithio'n gorfod bod yn gyson â Mesur y Gymraeg. Hefyd, prif nod Comisiynydd y Gymraeg yw hybu a hwyluso defnyddio'r Gymraeg ac nid yw Mesur y Gymraeg yn cyfeirio at 'wella gwasanaethau cyhoeddus'.

Barn y Comisiynydd yw bod mecanwaith effeithiol ar gyfer gweithio cyfochrog eisoes ar gael yn Mesur y Gymraeg. Wrth ystyried priod waith y gwahanol gorfforaethau un-dyn nid yw'n amlwg pa werth ychwanegol ddeuai o bennu swyddogaeth gydlynol yn hytrach na rhoi pwyslais cryfach ar weithio cyfochrog. Hefyd mae'n rhaid i annibyniaeth barn Comisiynwyr, yr Ombwdsmon ac Archwilydd Cyffredinol Cymru gael ei warchod.

- Cwynion llafar

Mae'r Ombwdsmon wedi dweud yr hoffai dderbyn cwynion ar lafar. Mae'n rhaid i gwynion gaiff eu cyflwyno i Gomisiynydd y Gymraeg o dan delerau Deddf yr Iaith Gymraeg 1993 [18(1)(a)] a Mesur y Gymraeg 2011 [93 (4)] fod ar ffurf ysgrifenedig. Ychwanega Mesur y Gymraeg y geiriau canlynol "*oni bai bod amgylchiadau personol P yn golygu na fyddai'n rhesymol i P wneud y gŵyn yn ysgrifenedig*". Yng nghyswllt Comisiynydd y Gymraeg nid yw'n ymddangos bod angen ymestyn ar y diffiniad sydd eisoes yn Mesur y Gymraeg. Mae gosod disgwyliad ar y Comisiynydd i ystyried yr amgylchiadau cyn derbyn cwyn lafar yn rhesymol ac yn sicrhau tegwch i unrhyw sefydliad all fod yn wrthrych unrhyw honiad.

Mae'r Comisiynydd yn cytuno bod hygyrchedd i'r achwynydd yn bwysig mewn amryfal ffyrdd. Dylai'r Ombwdsmon fod â chyfleuster i dderbyn cwynion ysgrifenedig yn Gymraeg a'r Saesneg fel ei gilydd a, lle bo hynny'n rhesymol, dylid ymestyn yr hawl i dderbyn cwynion ar lafar yn y ddwy iaith.

- Ymdrin â chwynion ar draws y gwasanaethau cyhoeddus

Rhoddir sylw gan y pwyllgor i gryfhau rôl yr Ombwdsmon mewn cysylltiad â pholisi cwynion a chyfeirir at bolisi gwirfoddol Llywodraeth Cymru fel enghraifft i'w ystyried.

Comisiynydd y Gymraeg
Welsh Language Commissioner

Mae Comisiynydd y Gymraeg yn gyfrifol ar hyn o bryd am weithrediad cynlluniau iaith Gymraeg. Dros gyfnod o flynyddoedd caiff y cynlluniau iaith eu disodli gan Safonau'r Gymraeg. Newid graddol fydd hyn ac y mae disgwyl i nifer sylweddol o gynlluniau iaith barhau i fod mewn grym am beth amser i ddod.

Mae'r cynlluniau iaith yn weithredol gan gyrff y Goron ac adrannau Llywodraeth Prydain a'u hasiantaethau anatganoledig yn ogystal â sefydliadau cyhoeddus yng Nghymru. Maent yn weithredol gan rai yn y sector preifat megis y diwydiant dŵr. Bydd Safonau hefyd yn berthnasol i'r un cwmpas o sefydliadau ac y mae'r potensial yn ehangach na hynny. Mae cylch gorchwyl y Comisiynydd hefyd yn ymestyn i'r maes gweinyddu cyfiawnder yng Nghymru yn rhinwedd Rhan III o Ddeddf yr Iaith Gymraeg.

Ceir diffiniad statudol o ystyr cwyn[6] mewn cysylltiad â'r Gymraeg mewn deddfwriaeth. Bydd rheoliadau Safonau'r Gymraeg eu hunain yn cynnwys gofynion pendant ynghylch cwynion yn ymwneud â'r Gymraeg a bydd yn rhaid i sefydliadau gydymffurfio gyda'r gofynion fydd arnynt. Polisi Gorfodi Comisiynydd y Gymraeg yw'r polisi sy'n amlinellu trefn cwynion Comisiynydd y Gymraeg.

Byddai'n rhaid i un polisi generig o dan awdurdodaeth yr Ombwdsmon allu bod yn ddigon hyblyg i lwyr adlewyrchu gofynion deddfwriaeth endidau eraill gan gynnwys deddf yr Iaith Gymraeg 1993, Mesur y Gymraeg ac is ddeddfwriaeth cyfatebol yn achos Comisiynydd y Gymraeg. Ymhellach mae'n hanfodol ystyried rôl Tribiwnlys y Gymraeg wrth roi sylw i drefniadau gorfodi Comisiynydd y Gymraeg.

Dylid ystyried beth yw diben sefydlu un polisi cwynion generig. Cafodd Comisiynydd y Gymraeg ei sefydlu fel endid a fyddai'n canolbwyntio'n llwyr ar un maes llafur sef yr iaith Gymraeg. Wrth fynd i'r afael a chwynion mae'n rhesymol bod gan y Comisiynydd hyblygrwydd i wneud fel yn briodol yng nghyswllt ei phrif nod o hybu a hwyluso defnyddio'r Gymraeg. Mae'n hanfodol ei bod yn gallu ymwneud gyda chymunedau a thrafod profiadau defnyddwyr y Gymraeg gan addasu ymagwedd ar sail trafodaeth a phrofiad sefydliadol. Mae datrysiadau Comisiynydd y Gymraeg yn cael eu gweithredu a'u derbyn gan sefydliadau ar hyn o bryd. Os yw'r Senedd eisoes wedi gweld yn dda i greu endidau drwy gyfraith er mwyn arbenigo mewn maes llafur penodol a gyrru newid ac y mae hyn yn rhywbeth na ddylid ei golli.

- Awdurdodaeth yr Ombwdsmon

Mae datblygu awdurdodaeth yr Ombwdsmon ar sail yr egwyddor y dylid dilyn y dinesydd

[6] Gweler adran 18, deddf yr Iaith Gymraeg 1993 a hefyd adran 93, Mesur y Gymraeg (Cymru) 2011.

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Welsh Language Commissioner

yn rhywbeth i'w groesawu. Byddai angen ystyried ym mha fodd y gellid gwireddu'r ddelfryd mewn cyfraith. e.e. rhoi sylw i ystyr gwasanaethau o natur cyhoeddus ac ati. Wrth i natur sefydliadau newid gwelir llai o endidau'n cwympo o dan y diffiniad o fod yn 'gorff cyhoeddus'. Mae erydu hefyd wedi bod ar ystyr *gwasanaeth cyhoeddus*. Mae'r ystyr hwn hefyd yn newid rhwng un darn o ddeddfwriaeth ac un arall.

Trafodir y syniad o gynnwys atodlen o sefydliadau sydd o dan awdurdodaeth yr Ombwdsmon. Mae'r newid sydd wedi bod i swyddogaethau sefydliadau a'u cyfansoddiad ers pasio Mesur y Gymraeg yn pwysleisio doethineb mecanwaith sy'n sefyll prawf amser. Mae'n bwysig i ddefnyddwyr bod cylch gorchwyl yr Ombwdsmon yn un clir a chyfredol.

- Cysylltiadau â'r Llysoedd

Mae'r adolygiad yn ymwneud â sefydlu cyswllt â'r llysoedd. Fel rheoleiddiwr a chanddi bwerau gosod dyletswyddau a'u gorfodi rhoddodd Mesur y Gymraeg fecanweithiau yn eu lle i gadw Comisiynydd y Gymraeg yn atebol am rai o'i dyfarniadau. Un modd o wneud hyn fu i sicrhau bod gan sefydliadau ac unigolion y gallu i droi at Dribiwnlys y Gymraeg. Mae gan y Tribiwnlys rôl benodol iawn. Tu hwnt i hynny mae gan y Comisiynydd y gallu i fynd at Lys Sirol ac fe gaiff y Comisiynydd gychwyn neu ymyrryd mewn achos cyfreithiol. Mae'r pŵer hwn yn un eang.

Tra bod y Comisiynydd yn cefnogi egwyddor o sicrhau cyfiawnder i unigolion yn y modd rhwyddaf posibl mae hefyd yn hanfodol gwarchod y gwasanaeth unigryw mae'r Ombwdsmon eisoes yn ei gynnig.

- Materion eraill

Wrth ystyried gallu'r Ombwdsmon i wneud argymhellion sy'n rhai gorfodol mae'n fuddiol dwyn cymhariaeth â'r hyn ddywed Mesur y Gymraeg sef bod gorfodaeth yn arwain at gydymffurfiaeth â dyletswyddau a thrwy hynny'n rhoi hawliau i bobl. Wrth rymuso pwerau'r Ombwdsmon, fel yn achos y Comisiynydd, mae'n dilyn y bydd yn rhaid sicrhau rhagor o atebolrwydd. Ymhlyg wrth hyn bydd yn bwysig ystyried tarddiad rôl Ombwdsmon ynghyd â'r teitl a phwysigrwydd cadw at hanfodion y diffiniad.

Wrth roi sylw i atebolrwydd dylwn egluro wrth y Pwyllgor nad yw'r Ombwdsmon yn gweithredu cynllun iaith Gymraeg. Wrth adolygu'r ddeddfwriaeth, a phe bai'r Ombwdsmon am barhau i beidio â bod yn ddarostyngedig i Gomisiynydd y Gymraeg, dylid cynnwys darpariaeth ynghylch defnyddio'r Gymraeg o fewn y Mesur newydd neu ddiwygiedig.

Comisiynydd y Gymraeg
Welsh Language Commissioner

Wrth ystyried canlyniadau anfwriadol unrhyw newid neu gost a budd adolygu deddfwriaeth bydd yn bwysig adnabod y risgiau mwyaf. Efallai nad yw ystyried diwygiadau i'r Bil/deddf newydd ar sail economaidd yn unig yn llawn gwmpasu'r hyn sydd orau wrth bwyso a mesur pwysigrwydd swyddogaeth Ombwdsmon i gymdeithas. e.e. os yn ceisio cyfrif gwerth ymchwilio i achosion difrifol sut mae rhoi gwerth ariannol i fywyd? Mae'n bosibl y dylid cynnal asesiad effaith ar sail gwerthoedd yn y cyswllt hwn ac yn sicr bydd angen rhoi amser digonol i ystyried y materion sylfaenol sydd wrth wraidd rhai o'r cynigion.

Er bod rhai pwerau tebyg rhwng yr Ombwdsmon a Chomisiynydd y Gymraeg mae gwahaniaethau yn y rôl hefyd. Un elfen yn unig o waith y Comisiynydd yw mynd i'r afael â chwynion. Er hynny gobeithiaf bod y cyfraniad hwn o gymorth cychwynnol i'r Pwyllgor wrth iddo gynnal ei ymchwiliad. Byddwn yn falch o gael dod i drafod ymhellach â chi pe bai'r Pwyllgor yn dymuno hynny yn y dyfodol.

Yr eiddoch yn gywir,

Meri Huws
Comisiynydd y Gymraeg

Policy Response

Consideration of powers: Public Services Ombudsman for Wales

A response from WCVA

24 February 2015

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Wales Council for Voluntary Action

A response to the consultation: Consideration of powers: Public Services Ombudsman for Wales

Background

Wales Council for Voluntary Action (WCVA) is a registered charity and umbrella body working to support, develop and represent Wales' third sector at UK and national level. We have over 3,350 organisations in direct membership, and are in touch with many more organisations through a wide range of national and local networks. WCVA's mission is to provide excellent support, leadership and an influential voice for the third sector and volunteering in Wales.

WCVA is committed to a strong and active third sector building resilient, cohesive and inclusive communities, giving people a stake in their future through their own actions and services, creating a strong, healthy and fair society and demonstrating the value of volunteering and community engagement.

We believe that there is an urgent need to transform public services in Wales by treating people and communities as assets and equals in design and delivery; building services around the person and community; unlocking potential resources of time, money and expertise to combine with state funding; using existing state resources to enable and maximise citizen and community action, capital and care. We are calling for a different public service: one which places the citizen and community at the centre, with the state as the enabler and facilitator. Our policy position statement *Putting People at the Centre*, is available via this link and on our website.

We welcome the opportunity to respond to the Finance Committee's inquiry into the Consideration of Powers of the Public Services Ombudsman for Wales.

Introduction

The Welsh Government and public bodies take decisions on a daily basis which affect important aspects of people's lives such as family incomes, employment and training, health and social care, housing, and education.

So, it is vital that people know what they are entitled to when officials make decisions, and where they can turn to when things go wrong. The Public Services Ombudsman for Wales (PSOW) provides access to justice, standing between the relatively weak individual citizen and powerful state organisations, giving them the right to have their complaints investigated and putting things right when they have received a poor service by finding an appropriate remedy. In addition, the PSOW seeks to prevent further harm or injustice to other citizens or service users by identifying lessons learned through the course of investigations and recommending improvements in service delivery.

We believe granting the Ombudsman additional powers will better protect and promote the interests of all citizens.

1. *Own-initiative powers – this would enable the Ombudsman to initiate his own investigations without having first received a complaint about an issue*

   In recent decades Ombudsman schemes throughout the world have been evolving in order to provide better services to their citizens. One of the most important innovations is the acquisition of own initiative powers and there is considerable evidence from Australia, New Zealand, Canada and the majority of European countries that they are highly beneficial to the work of Ombudsmen. Recently, these

powers have been acquired by the Ombudsman in Northern Ireland and the Parliamentary and Health Service Ombudsman in England is in the process of seeking them. The direction of travel for modern Ombudsmen is to move away from being largely reactive to individual complaints to being much more proactive, seeking to influence stakeholders including public services, regulators and government as all share a common goal of wanting to deliver the best possible public services.

Ann Abraham suggests that Ombudsmen should have their own initiative powers in order to extend their "reach to all citizens and to adopt a genuinely inquisitorial approach and be able to respond to public outcry on behalf of the most vulnerable"; "in the absence of a specific individual complaint, the Ombudsman should not stand idly by." They should have the ability "to seize the initiative, to catch the whiff of scandal and run with it, especially if social justice is to reach some of the most vulnerable and marginalised people in society". (Ann Abraham, the Parliamentary Ombudsman and Administrative Justice: shaping the next 50 years, Tom Sargent Annual Memorial lecture 2011, Justice).

At present, the limitation of only having the power to investigate and remedy an individual complaint about the service of a sole public service provider prevents the PSOW from playing a preventative role: the PSOW is not able to investigate suspected widespread, systemic maladministration or service failure across Wales. The PSOW cannot carry out a thematic review to prevent all citizens from suffering the same poor service wherever they live. Own initiative powers would allow the PSOW to investigate the area of concern as a whole and recommend actions to be taken by all relevant public providers across Wales in order to improve the quality of services.

For example, the PSOW could undertake a thematic review of a specific service where information or intelligence suggests a worrying theme in terms of inadequate service or failure. Importantly, it would give the Ombudsman the ability to carry out an investigation in the early stages of suspected serious systemic failure. In the absence of a specific complaint, the PSOW could respond to public concerns about the treatment of the most vulnerable in our society: information or intelligence could be obtained from the media, the Complaints Wales Signposting Service, Citizens Advice Cymru, Age Cymru, Wales Audit Office, Healthcare Inspectorate Wales, CSSIW and Estyn amongst others.

It is possible that if the Parliamentary and Health Service Ombudsman in England had been able to use own initiative powers, action could have been taken at an early stage to tackle the serious shortcomings at Mid Staffordshire Hospital and many avoidable deaths prevented.

Both the Ombudsmen in Wales and in England are constrained in protecting the public as they can only investigate an individual complaint once the patient or service user has exhausted the internal complaints procedures of the public body – where their complaints are handled poorly this may take several years. In the meantime other service users remain at risk.

Andre Marin the Ombudsman for Ontario has a long track record of using own initiative powers and undertaking thematic reviews of services and suggest that the "primary function of an Ombudsman is to make robust enquiries designed to improve organisations and institutions so that future mishaps can be avoided."

They should do much more than only focusing their efforts on obtaining reparation case-by-case, carrying out thematic investigations can raise the quality of services for everyone who uses them. By conducting robust and deeper investigations into complaints to unearth the root causes of the problem, identifying national and

international benchmarks of good practice and making recommendations in special reports, the Ombudsman can become "the architect of better governance arrangements capable of eradicating the causes of the difficulties"; and systemic investigations are the "jewel in the crown of Ombudsman annual reports". (Marin, address to the IXth International Ombudsman Institute World Conference, Swedish Parliamentary Ombudsman Bicentennial, Stockholm, Sweden, 10th June 2009).

The possession of own initiative powers would enable the PSOW to contribute to the transformation and innovation of public services which is one of the primary recommendations of the Williams Commission. And by not only helping individual complainant's achieve redress, but also helping public agencies improve services, the PSOW can play a vital role in increasing trust in public services and government.

2. Oral complaints - at present, the Ombudsman can only accept complaints in writing

Ombudsmen across the UK want to increase access to services for underrepresented groups such as BME communities, children and young people, the unemployed and people with mental health problems. The power which limits the PSOW to only accept complaints in writing is a barrier for people who are socially excluded and marginalised. These barriers include limited literacy skills, English not being the citizen's first language, lack of experience of dealing with bureaucratic processes, and a lack of capacity to think and express oneself logically and clearly – for example, caused by dementia or mental health problems.

Also, although complainants have had their issues explored through the internal complaints processes of public providers, if their complaint has been handled inadequately through a failure to share information, a lack of support and poor decision-making they may be confused and lack sufficient clarity about the exact nature of their complaint. And they may be angry and distressed suffering from "complaints exhaustion", therefore they would greatly benefit from receiving support from PSOW staff to make an oral complaint to the office: it is vital that the complainant and complaints handler have a full understanding and are able to agree precisely the nature of the complaint. The provision of advocacy and communication support for example sign language is fundamental.

The ability to receive complaints orally, either face-to-face or by telephone, by smart phone or online as well as in writing promotes equal access for all citizens and should cover all public services not just the PSOW.

In order to further embed equality and diversity it would be helpful if all organisations gathered data and analysed their complaints to identify which social groups are underrepresented and then developed an access strategy and action plan.

3. Complaints handling across public services – this would enable the Ombudsman to have a role in advising on complaints handling across public services

The PSOW's Model Complaints Policy applies to all public services in Wales (the complaints policy for the NHS, Putting Things Right follows the same principles).

This policy sets an excellent standard for the way complaints should be handled, how they can be resolved and contribute to improving service quality. Currently public agencies adopt the policy on a voluntary basis, however, if it became statutory guidance, the results would include quicker implementation across the public sector as well as normalising a positive complaints culture across Wales. It would transform negative attitudes where they exist and promote a learning culture where complaints are seen as a gift and an opportunity to deliver better services. So

citizens, and people who use services could expect more responsive and higher quality services from the various public organisations they come into contact with.

Also, the PSOW should be given powers which would allow the PSOW to consider and adapt the Scottish Ombudsman's approach to complaints handling for Wales.

There is a similar Model Complaints Policy in Scotland and there the Ombudsman has created a specialist unit within the office (the Complaints Handling Authority) whose role is to develop excellent complaints handling across the whole of the public sector.

Key aims include:

- To simplify and standardise the design and operation of complaints handling procedures across the public sector in line with the overarching model complaints policy.
- To promote good complaints handling by providing tailored advice for each public provider on how they can improve their complaints handling processes and culture.
- To facilitate the sharing of best practice between public providers.
- To monitor the complaints handling performance of public providers.

The Ombudsman has used their powers to bring together key institutions and lead the creation of sector specific complaints handling processes for the NHS, local government, the Scottish Government, and Registered Social Landlords.

Also, the Ombudsman has created a Training Unit, which provides training courses on model complaints handling for each sector and classroom training is supported by e-learning courses.

The model followed in the NHS has been replicated in all sectors. The Ombudsman has established and coordinates a nationwide network of complaints handlers working in the NHS, a website has been created, and there is a programme of face-to-face training events as well as the availability of online training tools.

Of particular interest are online training tools which can be accessed by frontline staff in the NHS, focused on enhancing their abilities to deliver customer-centred care *ie*, listening to patients and responding positively to their concerns and complaints.

The benefits of this approach include raising the status and skills of internal complaint handlers enabling them to deliver a better service to patients and service users. In Wales, a network of complaints handlers exists, but to date it has not progressed as far as the Scottish model.

Also in Scotland, each sector has developed a standardised performance reporting framework, identifying key data and information which must be gathered and these are benchmarked against indicators set by the Ombudsman.

With adequate powers and resources the Scottish approach adapted for Wales suggests a range of possibilities for the PSOW:

- The Model Complaints Policy to become statutory guidance and implemented at the earliest opportunity by all public services and authorities.
- The Ombudsman to work in partnership with service providers, regulators and other stakeholders to develop sector specific complaints handling processes in line with the Model Complaints Policy. This would result in the creation of learning exchanges or networks of complaints handlers in the NHS, local government, Registered Social Landlords, further and higher education, the Welsh Government and other public authorities.

- Standardised performance management frameworks enabling each public organisation's complaints activities to be evaluated against benchmarked standards. Each public body to produce an annual report summarising all complaints received, what lessons have been learned, and how services have been improved as a result.
- The establishment of a training unit to offer face-to-face and online training courses.
- The PSOW to provide a dedicated website for complaint handlers across Wales. It would be a central information point for complaint handlers and allow them to share best practice. The website could provide information on the model complaints handling process for each sector; stipulation of the requirement to implement the model; good practice guidance on complaints handling; links to sources of information and best practice in complaints handling; an online community forum enabling the sharing of best practice in the complaints handling community, both within and between sectors; the Ombudsman's e-learning resources on complaints handling; and information on training courses offered by the training unit.

It is worth outlining the Scottish Ombudsman's generic e-learning training course which is the starting point for all public sector staff as it is a quick and cost-effective way of disseminating good practice information. Particularly useful is that it is interactive, allowing learners to practice new skills or knowledge in a complaints scenario and they are given feedback on their performance and areas for improvement are identified. It includes eight modules:

1. Understanding the model complaints procedure.
2. What is a complaint?
3. What customers want when they complain.
4. Getting it right from the start.
5. Active listening.
6. Finding the right solution.
7. Learning from complaints.
8. Managing difficult behaviour.

In Wales, this generic course could be made available and built upon for each sector – in the first instance, top priority could be given to the development of an e-learning module on complaints handling for NHS staff.

In conclusion, giving the PSOW new powers to improve complaints handling across public services could help address existing problems and result in a significant reduction in the number of unnecessary complaints the PSOW has to deal with.

Since the Ombudsman's service became available, the number of complaints has increased year on year.

For example, health service complaints have increased by 257% since 2006 and now comprise 37% of the caseload.

The Ombudsman's casebook and special investigation reports show that for many years that resources could have been used elsewhere if public service organisations had handled complaints better. When they fail to resolve complaints at the local level, they have escalated to the Ombudsman.

As suggested, the new powers would enable the Ombudsman to develop a range of initiatives to help public service providers to "get it right first time" *ie*, deliver excellent services, better customer care, accept complaints as a gift resolving them quickly at the local level and using them to drive the improvement and innovation of services.

4. *The Ombudsman's jurisdiction (to include private health services) – this would extend the Ombudsman's jurisdiction to include private health services where patients had accessed public and private health care*

The PSOW should be given the powers and the responsibility to investigate complaints where patients have access to public and private healthcare. The foundation principle is that the Ombudsman should be able to follow the public sector pound: private sector or third sector organisations commissioned to deliver services by state bodies, the NHS or local government should fall within the PSOW's jurisdiction. People should have access to independent redress or remedy of their complaint across all sectors. Therefore, when services are outsourced to a private provider complaint handling processes should be specified in the contract and the provider should be required to follow either the Ombudsman's Model Complaints Policy or NHS arrangements as appropriate.

However there may be an issue of proportionality for local voluntary and community groups. Consideration should be given to where the line should be drawn regarding the inclusion and exclusion of organisations subject to investigation. It would be sensible to include organisations which are substantially funded by public bodies and in formal contract relationships, but it may be inappropriate to include some voluntary and community groups which receive only small revenue grants from local authorities. Our view is that this could place an undue burden on relatively small organisations.

Complaints processes should be citizen centred rather than sector centred. Contracts to deliver public services should require providers to have an appropriate complaints handling processes in place, in line with the PSOW Model Complaints Policy.

At present, the PSOW cannot deal with matters or complaints which are the responsibility of UK Government Departments *eg*, benefits, pensions, child support and immigration matters. Currently, they are the responsibility of the UK Parliamentary and Health Services Ombudsman who recently identified concerns that complaints about these services from Wales, Scotland and Northern Ireland are very low *(Public Administration Committee, House of Commons, 16 December 2013)*.

There is much consensus amongst Ombudsmen that the administrative justice landscape is complex and too fragmented and many people find it confusing when they wish to make a complaint. They hold that the ideal complaints system should be simple and accessible. The previous PSOW and the Scottish Ombudsman recently suggested that they should be able to provide a "one-stop shop" being responsible for complaints about all public services, both devolved and non-devolved. (House of Commons, Public Administration Committee 10 December 2013). It would be useful to explore the possible benefits of this approach with the non-statutory advisory body, namely the Committee for Administrative Justice and Tribunals Wales. For example, there is the potential to agree Memoranda of Understanding between the UK and Welsh Governments.

And in the light of the possible devolution of more powers to Wales it will be important for the PSOW and the Committee to look at how administrative justice processes should be adapted to ensure that citizens have a right to complain and achieve proper redress when things go wrong.

5. *Links with the courts - the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review (this would give complainants the opportunity to decide which route is most appropriate for them)*

At times, the Ombudsman can be an effective alternative to the court system, offering an easier and cheaper means of resolving disputes between citizens and public service providers. The majority of complainants, especially people who are vulnerable and marginalised do not have the financial resources to take their grievances to court, therefore there should more opportunities to take advantage of the free services provided by the PSOW.

It is often inappropriate for courts to expend scarce and expensive resources on resolving disputes which can be better dealt with by the PSOW. Unlike the judiciary which must strictly apply objective legal standards and disputes, the Ombudsman is guided by a set of principles, not rules, for example the Principles of Good Administration, Principles for Remedy and Model Complaints Policy. Therefore, the PSOW's judgements are based on what is fair and reasonable rather than a strict test of legality.

Another aspect relating to the removal of the statutory bar is that it should increase choice and access for complainants. Provided that good information and advice is available to the public, including independent advocacy, WCVA supports this as a useful development.

Conclusion

This submission provides evidence supporting all of the new powers requested by the Public Services Ombudsman for Wales as it will enable the PSOW to deliver a better service for all citizens: not just individual complainants, but also where necessary, making a significant contribution to the improvement and transformation of public services.

Without own initiative powers the strategic role and impact of the PSOW is weakened.

Allowing a wider means of submitting complaints including oral complaints will increase access.

Advising across public services improves consistency and quality.

The public have a right to independent redress regardless of the service provider.

WCVA is keen to further develop its links and work with the PSOW in the spirit of putting people at the centre of the design, development and delivery of public services. WCVA can not only bring access to the expertise of the third sector in Wales regarding working with particular groups of people, and notes in particular, the expertise of Participation Cymru on best practice in engagement and scrutiny.

RM
WCVA
February 2015

NATIONAL ASSEMBLY FOR WALES FINANCE COMMITTEE

CONSIDERATION OF POWERS: PUBLIC SERVICES OMBUDSMAN FOR WALES

WRITTEN EVIDENCE SUBMITTED BY THE LAW COMMISSION OF ENGLAND AND WALES, FEBRUARY 2015

1.1 The Law Commission of England and Wales ("the Law Commission") welcomes the invitation to give evidence to the Finance Committee in relation to its consideration of powers held by the Public Services Ombudsman for Wales ('PSOW').

1.2 The PSOW has asked that his powers be reviewed and has submitted proposals to the Committee around five key areas of change:

1.2.1 Own initiative investigations

1.2.2 Access – oral complaints

1.2.3 Complaint Standards Authority

1.2.4 Extension and reform of jurisdiction - Healthcare

1.2.5 Links with the courts

1.3 The Law Commission has previously reviewed the legislation governing public services ombudsmen in England and Wales. We undertook a consultation between 2 September 2010 and 3 December 2010 ("the 2010 consultation").[1] A final report making recommendations was published 13 July 2011 ("the Report").[2] In the Report we made 17 recommendations for change. Those recommendations which relate to the areas of change identified by the PSOW, specifically access to the ombudsman and links with the courts, are discussed further below.

1.4 In producing this evidence, the Commission is able to draw on responses to our consultation and the recommendations in our Report. We are also able to update the Committee in respect of what has happened post publication of the Report.

[1] Public Services Ombudsman – A Consultation Paper Law Commission No 196

[2] Public Services Ombudsman Law Commission No 329 July 2011

1.5 We concluded our work on public services ombudsmen in 2011, since when we have undertaken other projects and have not done any further work on ombudsmen. The consultation responses which informed the Commission's views were received in 2010. We are constrained, in providing this evidence, to outlining the Commission's thinking at the time of preparing the Report and briefly describing what has happened subsequently within Government.

1.6 This note is divided into five sections:

(1) Background to the Law Commission;

(2) The Public Services Ombudsman project;

(3) Access – oral complaints;

(4) Links with the Courts; and

(5) Report update.

SECTION 1 - Background to the Law Commission

1.7 The Law Commission is an independent body created by Parliament by the Law Commissions Act 1965, as subsequently amended. The role of the Commission includes keeping all the law of England and Wales under review, providing advice and information to the English and Welsh Governments, and recommending reform where it is needed. The driving principle of all our law reform work is to ensure that the law is fair, modern, accessible and as cost-effective as possible.

1.8 The Commission is led by a Lord Justice of Appeal as Chairman. Five specialist teams of lawyers and researchers work under the supervision of the Chairman and 4 other full-time Law Commissioners.

1.9 Recommendations that the Commission should review an area of law are made by a wide variety of people, including the judiciary, Members of Parliament or the Welsh Assembly, Government Departments and other Government bodies in England and Wales, as well as by voluntary and private sector organisations and individuals. Periodically the Commission holds a consultation, calling for ideas for projects for the next 3 year programme of law reform.

1.10 The Commission is required to "prepare and submit to the Minister from time to time programmes for the examination of different branches of the law with a view to reform".[3] Under the terms of a Protocol agreed between the Lord Chancellor (on behalf of the United Kingdom Government) and the Law Commission,[4] only projects that are appropriate for the Commission and have a reasonable expectation of implementation are selected for a programme. The selection criteria include an examination of the extent to which the law is unsatisfactory (for example, unfair, unduly complex, inaccessible or outdated).

[3] Section 3(1)(b) Law Commissions Act 1965

[4] Dated March 2010,

1.11 Amendments made to the Law Commissions Act by the Wales Act 2014 include the creation of a specific power of the Commission to provide advice and information to the Welsh Ministers[5] and to agree with the Welsh Ministers a separate protocol about the Law Commission's work relating to Welsh devolved matters.[6] The Law Commission is currently undertaking two projects, relating to the form and accessibility of the law in Wales and to planning and development control in Wales, that relate to devolved matters.

1.12 Consultation is key to law reform projects undertaken by the Commission. It allows the Commission to gain a thorough understanding of the operation of the area of law with which we are concerned, the problems that arise and how they are experienced by the public. Driven by the publication of a detailed consultation paper, the Commission's extensive consultation process informs and strengthens our final recommendations.

1.13 Consultees will normally include politicians, officials and legal advisers from Government departments, the judiciary, practising lawyers, legal academics, local government, trade and industry, consumer groups, representative and campaigning organisations in the business and voluntary sectors and the public at large.

1.14 Scrutiny of the Commission's work comes both internally and externally – internally through peer review by all Commissioners of each project and externally through consultation. Peer review takes place at each of the key stages in a project.

SECTION 2 – The Public Services Ombudsman project

1.15 The Commission originally published a consultation paper in July 2008 entitled *Administrative Redress: Public Bodies and the Citizen*.[7] That consultation paper considered three primary aspects of administrative redress: judicial review, private law actions against public bodies, and ombudsmen. The first two aspects of the project were discontinued for the reasons given in the Commission's report of May 2010,[8] but our work on public services ombudsmen continued.

1.16 In relation to ombudsmen the 2008 consultation paper had made four provisional proposals:

(1) the creation of a specific power to stay an application for judicial review, so that suitable matters are handled by ombudsmen rather than the courts;

[5] Law Commissions Act 1965 (as amended) s 3(1)(ea).

[6] Law Commissions Act 1965 (as amended) s 3D.

[7] Administrative Redress: Public Bodies and the Citizen (2008) Law Commission Consultation Paper No 187 (hereafter CP 187).

[8] Administrative Redress: Public Bodies and the Citizen (2010) Law Commission No 322.

(2) that access to the ombudsmen could be improved by modifying the "statutory bar" – the rule that recourse may not be had to the ombudsmen if the complaint has been or could be pursued in a court of law;

(3) a power for the ombudsmen to refer a point of law to the courts; and

(4) the removal of the "MP filter" in relation to the Parliamentary Commissioner for Administration, to allow a complainant direct access to the ombudsman without having first to submit the complaint to a Member of Parliament.

1.17 These provisional proposals mostly met with favourable consultation responses; however, certain consultees thought that the proposals needed to be developed further. During the 2008 consultation other issues also came to light which we felt were worth investigation. In the report of May 2010, the Commission stated its intention undertake further work on the public services ombudsmen; we published a further consultation paper in 2010.[9]

1.18 The 2010 consultation focused on the Parliamentary Commissioner for Administration; the Health Service Ombudsman; the Local Government Ombudsman; the Housing Ombudsman (although not all proposals applied to this post); and the Public Services Ombudsman for Wales.

1.19 The Commission received fifty-seven formal responses to the 2010 consultation. These came from a range of consultees, including: the public services ombudsmen; other public bodies; non-governmental organisations; members of the legal profession; and academics.[10]

1.20 The Commission set certain limits to the project. In the original administrative redress project our aim in relation to the ombudsmen was to "strengthen and clarify"[11] the relationship between the ombudsmen and courts. This precluded proposing fundamental change to either the number of public services ombudsmen or their individual remits. The 2010 consultation did widen the subject matter to include such matters as reporting, but this was in the context of facilitating the work of the existing ombudsmen.

1.21 In keeping with the Commission's decision not to alter the fundamental design of the ombudsmen, we considered the subject-matter which they investigate as lying outside the scope of the project.

1.22 Following consultation between September and December 2010, the Commission published its final Report in July 2011. The Report contained 17 recommendations, of which the following five are relevant to the areas of possible change which are the focus of this inquiry:

[9] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196.

[10] A complete list of those who submitted responses can be found in Annex A to the Consultation Analysis, available to download from the Law Commission Website (http://lawcommission.justice.gov.uk/areas/public-services-ombudsmen.htm).

[11] Administrative Redress: Public Bodies and the Citizen (2008) Law Commission Consultation Paper No 187, para 5.1. An exception to this general approach was the proposed reform of the "MP filter" relating to the Parliamentary Commissioner.

1 That the government establish a wide-ranging review of the public services ombudsmen's role as institutions for administrative justice.

2 That all formal, statutory requirements that complaints submitted to the public services ombudsmen be written be repealed, even where there is presently discretion to waive the requirement.

That the public services ombudsmen publish, and update regularly, guidance as to how complaints can be made.

3 That the statutory bar[12] be replaced with the discretion for the ombudsman to take a claim unless they decide it is not appropriate.

That the public services ombudsmen publish guidance detailing where it is appropriate to make a complaint to them, and where it would be more appropriate to make use of a court or other mechanism for administrative justice.

4 That the Administrative Court should have an express power to stay an action before it, in order to allow a public services ombudsman to investigate or otherwise dispose of the matter.

That the stay of an action should not force a public services ombudsman to accept a complaint.

5 That the ombudsmen be given a specific power to make a reference to the Administrative Court asking a question on a point of law.[13]

That intervention in the court proceedings by the parties to the original dispute should be allowed.

That the ombudsmen should be required to notify the parties before making a reference, inviting them to make representations and advising them of their ability to intervene should they want to.

That the decision to make a reference should be that of the relevant public services ombudsman alone.

That the reference should have to pass the permission stage.

That the opinion of the Administrative Court should be considered a judgment of the Court and, therefore, potentially subject to appeal to the Court of Appeal.

That the public services ombudsmen should meet their own costs.

Where parties intervene, that they should normally meet their own costs.

[12] The rule that recourse may not be had to the ombudsmen if the complaint has been or could be pursued in a court of law.

[13] This was recommendation number '7' in the Report.

SECTION 3 – Access – oral complaints

1.23 The governing statutes for the public services ombudsmen contain a variety of approaches to whether a complaint should be made in writing. The statutory provisions governing the Public Services Ombudsman for Wales allow the ombudsman to dispense with a written complaint.[14]

1.24 At the time of embarking upon the 2010 consultation, we considered there to be no reason to alter the current position of the Public Services Ombudsman for Wales in this respect. However, following receipt of all consultation responses, we concluded that there was no need for any statutory requirements as to the form in which complaints to ombudsmen were made. We thought that removing these would allow public services ombudsmen to react to technological developments and changing preferences of service users without the need either for reform of the governing legislation or routine exercises of discretion to waive the requirement of a complaint in writing so as to keep pace with such developments or other changes.

1.25 We were also concerned to ensure that the system was open and transparent. Therefore, we recommended that the public services ombudsmen publish and regularly update guidance as to how complaints can be made (although we did not recommend a statutory requirement to do this).

1.26 The Commission considered that there were advantages to reforming the formal requirements for making a complaint to the ombudsmen; we thought that our recommendation might have a particularly beneficial impact on individuals who have physical problems writing, who are illiterate or have reduced literacy, or who are not first language English or Welsh speakers.

1.27 We also thought that there may be cost advantages to allowing non-written complaints. Users could save in postage costs. Ombudsmen could save processing time and postage.

SECTION 4 - Links with the Courts

Setting aside the statutory bars

1.28 By the “statutory bars”, we meant the statutory provisions whereby a public services ombudsman cannot open an investigation if the complainant has or had the possibility of recourse to a court, tribunal or other mechanism for review, unless it was not reasonable to expect the complainant to resort or to have resorted to it. The purpose of these provisions was to prevent an overlap between the jurisdiction of the courts and that of the ombudsmen. In the case of the PSOW the statutory bar is contained in the Public Services Ombudsman (Wales) Act 2005, s 9.

[14] Public Services Ombudsman (Wales) Act 2005, ss 2(4) and 5(1)(a).

1.29 The Commission considered that there had been a considerable expansion in the scope of judicial review, such that there was a clear overlap between the jurisdiction of the ombudsmen and judicial review. However, the effect of the statutory bars was to create a preference in favour of the Administrative Court, where (but for the existence of the statutory bar) both the Administrative Court and the ombudsman could potentially consider a particular matter.[15]

1.30 Proposals to reform the statutory bars were set out in the Commission's 2010 consultation paper where we proposed their complete removal to allow the public services ombudsmen to take complaints where they thought it appropriate.[16]

1.31 Specifically, the Commission made three provisional proposals in relation the statutory bars:

(1) We provisionally proposed that the existing statutory bars be reformed, creating a general presumption in favour of a public services ombudsman being able to open an investigation.[17]

(2) We provisionally proposed that this should be coupled with a broad discretion allowing the public services ombudsmen to decline to open an investigation.[18]

(3) We provisionally proposed that in deciding whether to exercise that discretion the public services ombudsmen should ask themselves whether the complainant has already had or should have had recourse to a court or tribunal.[19]

1.32 These provisional proposals met with substantial approval.

1.33 The Commission therefore recommended that the statutory bars as they relate to courts be repealed and replaced with a discretion for the ombudsmen to open an investigation, or otherwise dispose of a matter (for instance by referring it to mediation). This would give complainants greater freedom of choice over the form of redress they use.

1.34 Following consultation, the Commission did not think it necessary to define in statute the discretion available to the public services ombudsmen when deciding not to investigate a complaint. Decisions would still be open to challenge on normal public law grounds, which we thought would provide sufficient protection from irrational decision-making.

[15] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 4.46.

[16] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, paras 4.38 to 4.46.

[17] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 4.42.

[18] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 4.47.

[19] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 4.47.

1.35 In response to the consultation, concerns were raised that individuals may not know which redress mechanism to use. By submitting an inappropriate complaint to an ombudsman, an individual may lose the opportunity to use a court or tribunal owing to the limitation periods for bringing proceedings. Given the fact that many individuals seek legal advice on important matters, we did not think that this would be a significant problem. However, we accepted there was the potential for a limited number of individuals to be affected.

1.36 In order to reduce the chance of individuals being detrimentally affected by the removal of the statutory bars, the Commission recommend that the ombudsmen publish guidance as to whether they are the appropriate mechanism for particular classes or sorts of complaint or whether it would be advisable for complainants to use other institutions. We appreciated that this happens already, but thought that the situation would be different without the statutory bars and new guidance should reflect this.

Stay provisions

1.37 The Commission saw that it was possible for a matter to come before the Administrative Court, at the permission stage, where there was a sufficiently arguable case on administrative law illegality for permission to bring the proceedings to be granted, but where it was apparent to the court that the true nature of the matter (whether categorised as a dispute or not) concerned maladministration.

1.38 In such a situation, we thought that the appropriate institution to deal with the matter would be one of the public services ombudsmen.

1.39 In the 2010 consultation, the Commission provisionally proposed that a matter be stayed and then "transferred" to the ombudsmen from the Administrative Court, when the court thought this suitable.[20] This would not be an actual transfer in the strict legal sense, as the court would not be moving the case before it to the ombudsmen; however, the term was used to emphasise a change in the institution that would consider the dispute.

1.40 We made one provisional proposal and asked three consultation questions.

1.41 First, we provisionally proposed that there should be a stay and transfer power allowing matters to be transferred from the courts to the public services ombudsmen.[21]

1.42 The three consultation questions were as follows:

(1) whether consultees agreed that the court should invite submissions from the original parties before transferring the matter;[22]

[20] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, paras 4.48 to 4.75.

[21] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 4.76.

[22] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 4.77.

(2) whether, in the event of such a transfer, the ombudsman should be obliged to open an investigation;[23] and

(3) whether the ombudsman should also be able to abandon the investigation should it – in his or her opinion – not disclose maladministration.[24]

1.43 The basic proposal to create stay provisions seemed acceptable to consultees. The requirement that the parties be invited to make submissions before a matter is stayed was also acceptable. However, there was considerable opposition to the proposal that the ombudsmen should be obliged to open an investigation, even if they could close it subsequently.

1.44 Given the consultation responses, we considered our provisional proposals in further detail.

1.45 The Commission considered that the mechanism would normally be used at the permission stage; however, we did not think that a stay needed to be granted before permission. We therefore suggested creating a general power to allow an action to be stayed either before or after permission.

1.46 The Commission considered that parties should be able to request that a matter was stayed. If that happened, it seemed sensible that the applicant should be able to make submissions (usually in writing) to the court on the specific point – which may raise issues different to those considered in their original application.

1.47 The Commission considered that where the court was, of its own motion, considering making an order to stay an action before it, it should seek written representations from the parties to the action before making such an order.

1.48 Following consultation, we concluded that we had been overly prescriptive in our proposals. We had provisionally proposed that the transfer of a matter should oblige the ombudsman to open an investigation. This proposal was revised in the final Report, as we thought that the better approach was for the transfer power to allow ombudsmen to dispose of a matter as they saw fit. The power should not require them to open an investigation.

1.49 The final issue we considered was what happened after the public services ombudsman had disposed of the matter, as there would still be stayed proceedings in existence. Where permission had not been granted by the Administrative Court, the findings of the public services ombudsman, or their refusal to investigate, could be considered at the permission stage. This would allow the Court to see whether there was still any issue of administrative illegality that it needed to consider. Where permission had already been granted, the Court could consider the ombudsmen's findings, or decision not to investigate, at any application to set aside the stay. At that stage, the Court could set aside the stay, either with or without further case management directions.

[23] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 4.78.

[24] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 4.79.

1.50 The Commission did not think that movement of a matter from a court to an ombudsman would necessarily lead to the ombudsman process becoming adversarial. We considered that the ombudsmen's processes were investigatory and the parties had to respond to that investigation rather than acting as they would in a court case. Given the discretion accorded to the ombudsmen by their governing statutes, we thought it hard to see how parties to the original case could upset the freedom of an ombudsman to dispose of a matter as the ombudsman saw fit.

1.51 We accepted that compelling an individual to move from the Administrative Court to a public services ombudsman would be an extreme measure. However, the Commission thought that there may be situations where compelling a complainant to move forum would be in the overall interests of justice.

1.52 If an ombudsman were to refuse to open an investigation, the complainant would be able return to the court with the refusal from the ombudsman and use that when arguing that the court should lift the stay, grant permission (if not already granted) and allow the matter to proceed to a hearing.

Reference on a point of law

1.53 The Commission thought there could be situations where the ombudsmen would be forced to abandon an investigation which otherwise they would be able to conclude due to a technical legal question that they were not equipped to resolve. In meetings with the public services ombudsmen, it had been suggested that such a power would also be useful to resolve occasional questions about the jurisdiction of the public services ombudsmen. We therefore thought that giving the public services ombudsmen the ability to pose a question of law to the Administrative Court would provide them with a useful tool which could facilitate their work.

1.54 In the Consultation we provisionally proposed a mechanism allowing the public services ombudsmen to ask a question of the Administrative Court.[25] We provisionally proposed that such a reference should bypass the court's permission stage.[26] We also suggested that the public services ombudsmen should meet their own costs were they to use such a mechanism.[27]

1.55 The Commission provisionally proposed that the decision of the Administrative Court should be subject to appeal to the Court of Appeal.[28]

[25] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 5.85.

[26] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 5.86.

[27] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 5.92.

[28] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 5.87.

1.56 We also provisionally proposed that the public services ombudsmen should notify the complainant and the relevant public bodies before making a reference, inviting them to submit their views and/or to intervene before the court.[29] When an intervention was made, the parties were to meet their own costs.[30]

1.57 While we thought it necessary for the ombudsman to consult those involved in a complaint before making a reference, we wanted to protect the ombudsmen's discretion. Consequently, we provisionally proposed that the final decision whether to refer a question to the court should be for the public services ombudsman alone.[31]

1.58 In general, the provisional proposals were broadly supported by consultees.

1.59 Our original intention behind the reference mechanism was to provide a tool which would to allow the ombudsmen to settle a matter concerning their own jurisdiction or to allow them to process a complaint which they would not otherwise have been able to deal with.

1.60 Certain consultees were concerned that the reference procedure might transform a closed investigation into an open one. We were not persuaded that this was an insurmountable obstacle. First, it was not the investigation as a whole that was being transferred, but a relevant legal question. Second, the courts already have mechanisms to deal with privacy – such as in certain cases involving children, where the parties are anonymised.

1.61 Several consultees raised the possibility of the reference procedure being misused by one side, either to cause additional delay or to impose extra costs on the other party. We considered that this missed the point that control of the mechanism remained with the ombudsman, and the discretion as to whether to make a reference lay with it solely.

1.62 We saw the key benefits as being the improvement of the quality of reports by increasing the ombudsmen's ability to report on technical legal matters, and preventing them from having to discontinue an investigation where a difficult legal issue arose. We thought that discontinuance of investigations could also have consequential costs for the parties involved, in that the issue may then have to go to court, with significant costs being incurred by both sides to the dispute.

SECTION 5 – Post-Report update

1.63 The Report was submitted to the Cabinet Office in 2011. In October 2013 the government established a wide-ranging review of the public services ombudsmen's role.

[29] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, paras 5.88 and 5.91.

[30] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 5.92.

[31] Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, para 5.89.

1.64 The review was led by Oliver Letwin, Minister for Government Policy, and a member of the Cabinet Office. This review looked at:

How to make it easier for the public to make a complaint, with a view to introducing a single ombudsman service, entered from one main portal.

How complaints are treated by civil servants, government departments, MPs and the NHS (this would include the ombudsman).

1.65 The Government is to publish the results of this review shortly, which will take the debate forward in terms of considering the role of the public services ombudsman. It is expected that the Commission's recommendations will feed into this wider review.

Response to Finance Committee Inquiry: Consideration of powers: Public Services Ombudsman for Wales

March 2015

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About Citizens Advice Cymru

1.1. Citizens Advice is an independent charity covering England and Wales operating as Citizens Advice Cymru in Wales with offices in Cardiff and Rhyl. There are 20 member Citizen Advice Bureaux in Wales, all of whom are members of Citizens Advice Cymru, delivering services from over 375 locations.

The twin aims of the Citizens Advice service are:

- to provide the advice people need for the problems they face
- to improve the policies and practices that affect people's lives.

1.2. The advice provided by the Citzens Advice service is free, independent, confidential and impartial, and available to everyone regardless of race, gender, disability, sexual orientation, religion, age or nationality.

1.3. The majority of Citzens Advice services staff are trained volunteers. All advice staff, whether paid or volunteer, are trained in advice giving skills and have regular updates on topic-specific training and access to topic-based specialist support.

1.4. Local Bureaux, under the terms of membership of Citizens Advice provide core advice based on a certificate of quality standards on welfare benefits/tax credits, debt, housing, financial products and services, consumer issues, employment, health, immigration and asylum, legal issues, and relationships and family matters.

1.5. The Citizens Advice Service now has responsibilities for consumer representation in Wales as a result of the UK Government's changes to the consumer landscape[1]. From 1st April 2014 this includes statutory functions and responsibilities to represent post and energy consumers.

Our response

2.1 From April to December 2014, in Wales, Citizens Advice Cymru helped 89,858 clients with 274,090 problems. A significant proportion of these related in some form to the administration of public services, both those that are under the jurisdiction of the Public Services Ombudsman (PSOW) and those that are non-devolved.

2.2 The PSOW plays a vital role in supporting people to have their concerns heard by an independent body. We strongly support the principles behind why the PSOW has made these suggested changes. In particular, we believe that it is key that any proposals strengthen the voice of people in Wales, their ability for redress and are based around how people access and use services. We believe it is important that public authorities value complaints and use them to make improvements to public services.

[1] On 1st April 2013 responsibility for consumer representation was transferred from Consumer Focus to the Citizens Advice Service (including Citizens Advice Cymru) following the UK Government's review of the consumer landscape.

Own initiative powers

3.1 Citizens Advice Cymru strongly support this proposal. Whilst the PSOW has seen an increase in the numbers of cases being referred over recent years, we know for every person that decides to make a complaint, there are many more that do not. Whilst the PSOW's role in individual cases is vital to support the principles of citizen redress, we believe it would be of substantial benefit for the PSOW to have the power to undertake investigations on their own initiative. This would be of particular value when looking across cases and seeing the connections between a range of issues and being able to undertake a strategic review of a whole service or sector.

3.2 From our own experience, we are often able to draw comparisons and trends from the cases which clients seek advice from us about. We use these to inform change to policies and practices. Therefore there is potential for the PSOW to drive service improvements in this way.

3.3 We believe that there is potential for much greater engagement with the PSOW if his powers were extended to enable own initiative investigations. Citizens Advice Cymru could play a role in sharing relevant strategic information with the PSOW about the types of issues that clients are facing, as well as raising specific issues within and across sectors that would benefit from investigation[2]. We would be in a position to do so, given our ability to not only look across our client evidence for Wales, but also draw insight from individual bureaux in terms of the trends they are seeing. We would also welcome the opportunity to be able to refer issues to the PSOW for review where we think there are/have been systematic failures, or have the potential to be.

3.4 In order to do so, it will be important, if the PSOW is given this power, that there are clear eligibility criteria and referral routes to do so, for ourselves and other stakeholders. We would also note that it is important that decision making about how investigations are chosen is open and transparent in order that advice agencies and others who may wish to make referrals have confidence in, and understanding of the parameters to engage in this process. Likewise it may be of value to consider where calls for evidence around such investigations would be useful to help inform these.

3.5 We also believe that it is vital that any investigations include an element of gathering views from the user perspective to ensure that this is central to any consideration of the issues and what might need to change.

3.6 This is would also be of benefit when considering areas of public services that people might not complain about.

3.7 We do feel consideration needs to be given to what the outcome of such an investigation would be and whether the PSOW's current powers go far enough in terms of enforcement of any decision. The aim should be tangible service improvements for both citizens and public services themselves. Therefore we would suggest that providers should have an action plan which includes time specific activities they must undertake and outcomes to achieve. The PSOW should also monitor and return to review whether the expected activities and outcomes have been

[2] Whilst of course retaining client confidentiality

achieved within the timescales agreed. As part of any further review, the user perspective will be important in terms of improvement in service and also user experience.

3.8 Raising awareness of sector failures may also raise greater awareness amongst the wider public of the ability to make individual complaints to the PSOW on such issues. Whilst we feel this is a positive, it is also worth being aware of the potential for an increase in caseload relating to this.

Oral complaints

4.1 Whilst the PSOW currently has discretion to accept a complaint in a form other than writing, if appropriate, considered on a case by case basis, we support the proposal that the PSOW be able to receive complaints orally as a matter of course. A discussion document commissioned by Consumer Focus looking at effective complaint handling[3] notes that evidence about how consumers contact companies and external redress schemes is that, at the moment, the vast majority of them use the phone, rather than email or post. This can also allow people to ask questions and explore options. Extending the ability to make a complaint would therefore extend access to people and may encourage them to explore the option of the PSOW, before making a formal complaint. We would note however that if this proposal is accepted that consideration should be given to the cost of calling, in particular for people on a mobile phone.

4.2 We also think that as part of the extension of the scope of how the PSOW receives complaints there should be specific consideration given to how people's communication preferences are changing in a digital age and that the PSOW can effectively respond to this. For instance, we know from our own research that more BSL users are now using Skype to communicate instead of typetalk.

4.3 In addition, we believe that it would be helpful to make clear in legislation that where people may be vulnerable, or do not feel confident to make a complaint themselves, that trusted intermediaries such as an advice agency are able to support people to bring a complaint to the PSOW on their behalf. We believe that individuals should have absolute discretion over who represents them.

Complaints handling across public services

5.1 We note that the PSOW has outlined in his written paper that take up of the Model Concerns and Complaints policy (the Policy) to date has been patchy. Without detailed analysis of which agencies have adopted the policy and extent to which the two stage complaints procedure has been implemented by all authorities, it is difficult to talk in detail about the specifics around the action public authorities need to undertake to improve their individual complaints procedures. However Citizens Advice Cymru does believe that a consistent complaints policy across public authorities in Wales would help people have a clear understanding about what to expect when making a complaint about a service or seeking redress.

[3] Consumer Focus (2013) Effective Complaint Handling- a discussion document: Written for Consumer Focus by Cosmo Graham, Professor of Law at the School of Law, University of Leicester and Director of the Centre for Consumers and Essential Services

5.2 In our view, the aim should be for public services to resolve any complaints quickly, effectively and in a satisfactory way for the citizen, first time. A part of this, is the authority recognising and acknowledging where there has been an error and making an apology as appropriate. It is fundamental however that the authority concerned is able to learn from the complaint to inform and improve service delivery and design. The Policy sets a comprehensive and clear template for public authorities to deliver against these expectations.

5.3 We would want to see all public authorities in Wales working along the lines of the principles outlined in the Policy. However as part of a move towards making the Policy mandatory, we feel it would be helpful to gather evidence as to why some authorities are not using this, as well as how those authorities who have adopted the Policy are finding this to date. This would enable any amendments to be made to the Policy based on feedback received and also specifically if any sector specific approaches need to be put in place to make it as practically applicable as possible and ensure that it can be used across sectors. As part of this, we also believe it is vital that feedback is sought from citizens who have complained to public authorities using the Policy to understand how the process worked from their perspective and if anything should be changed. This review process should also be repeated at regular intervals to ensure that the Policy remains current and responsive to the needs of both citizens and public authorities. Evaluation of the Policy will be essential to identify areas that require improvement and to learn from public services who demonstrate best practice in complaints handling.

5.4 One area that could be emphasized more strongly within the Policy would be the publication of outcomes of complaints. We believe that public services should demonstrate how complaints made to them resulted in improvements to the services being provided to users. We know from research by Consumer Focus Scotland that people want to know that other users did not have to experience similar problems and this would provide greater transparency on this issue[4].

A Complaints Handling Authority?

6.1 We also believe that the PSOW should be given powers to consider and adapt the Scottish PSOW's approach to complaints handling.

6.2 We believe that the establishment of a unit within the PSOW would enable a focus on driving up standards on complaints within public authorities and address the points made above regarding on mandatory Policy for all public authorities in Wales.

6.3 We believe as part of this the PSOW could also work in partnership with service providers, regulators and other stakeholders to develop sector specific complaints handling processes as appropriate (and identified through the above review).

6.4 Analysis and monitoring of complaints data across the public sector will also be important. We would like to see the PSOW taking a lead on the publication of complaints data by individual authorities, as noted above. We also believe that public service providers should be required to report, for instance through their annual

[4] Consumer Focus Scotland (2010) response to the Scottish Public Services PSOW consultation on "a statement of Complaints Handling Procedures and Guidance on a Model Complaints Handling Procedure"., page 5

reports and online, how many complaints were resolved at frontline stage, investigation stage and by the PSOW. This would provide citizens with greater transparency in terms of complaint handling and provide opportunities to explore where the balance may need to be changed. For instance, if it was found that very few complaints were resolved at the first level, understanding why this might be the case. By undertaking this work in Scotland, the Scottish Public Services PSOW has been able to develop a 'performance culture' in complaints handling[5].

6.5 To inform the development of the Model Complaints Handling procedure in Scotland, Consumer Focus Scotland worked with the Scottish Public Services PSOW to explore consumers' views of complaints handling procedures in public services. This informed the resulting procedure and provides useful insight into the benefits to the public of adopting such a procedure in Wales.

6.6 We would also argue that similar research should be undertaken with citizens in Wales as this model is rolled out.

6.7 It would also be useful to undertake research with the public to better understand complainant's experiences and the extent to which they are aware of the PSOW service. This should include seeking feedback from complainants, both those who have had their complaints accepted for consideration and those who have not, about what could have been done differently.

6.8 In the private sector, research conducted by Consumer Focus found that 65% of consumers were not told they could take their complaint to an independent body. We are not aware of any similar research to understand consumer experiences in the public sector in Wales but we suggest gathering such evidence directly from citizens would be beneficial to highlight any issues from a citizen perspective to inform any new responsibilities the PSOW receives in this area.

6.9 Complaints handling will vary across sectors so being more informed about citizens views and experiences would be helpful in helping to shape what the service looks like in future and ensure that those who have cause to access an independent body to investigate their complaint are aware of the PSOW and can easily access it.

The PSOW's jurisdiction

7.1 We support the proposal to extend the PSOW's remit to cover the private health sector. We believe people should have access to complaints and redress no matter what the service they access is. People's journeys through the health system can involve a range of funders and suppliers therefore their access to redress should be as joined up as possible. On the issue of funding, Citizens Advice Cymru receives funding to discharge its functions to represent energy and postal consumers from levies on those industries. This does not prevent us from providing challenge and also working alongside operators within those industries to raise issues and improve services for consumers.

7.2 We note that the PSOW written evidence suggests that it would be helpful in respect of private healthcare, to give him binding powers to implement a recommendation. We

[5] Scottish Public Services PSOW Annual Report (2013- 2014) Transforming Scotland's Complaints Culture, page 8.

would support this, but we believe that as outlined in the Law Commission's review[6] such binding powers should also be extended across his remit. We believe this will be key to go alongside new powers (if taken forward) to allow own initiative investigations as these may be more challenging in nature, given the potential for systematic review. We believe enabling binding powers across the PSOW's remit at this stage links with the principle of future proofing.

Links with the Courts

8.1 Citizens Advice Cymru agree with the proposal to remove the statutory bar to allow the PSOW to consider a case that has or had the possibility of recourse to a court, tribunal or other mechanism for review. We support the perspective that this would give complainants the opportunity to decide which route is most appropriate for them. In fact we believe given the financial and other barriers of access to the courts, this would give people greater access to redress. This would also have the benefit of enabling people to more easily access advice and advocacy to support them with their complaint.

8.2 We would support the Law Commission's recommendation around the issue that 'the Public Services PSOW publish guidance detailing where it is appropriate to make a complaint to them and where it would be more appropriate to make sure of a court of other mechanism of administrative justice'[7].

8.3 We also note the related issue of where the courts may consider the PSOW as a more appropriate route for claimants, namely stay provisions. We feel that it is therefore appropriate to mention this issue in our response. We believe that if the court believes that the PSOW is a more appropriate channel then it should have the power to stay an action before it, in order for the PSOW to choose to investigate the matter. Whilst the PSOW should not have an obligation to investigate, if he does not, we believe the complainant should be able to go back to the court for a decision on their initial complaint and further action by the court relating to this, as discussed by the Law Commission in their 2011 report[8].

Other

9.1 We believe that consideration should be given to including the Residential Property Tribunal within the scope of the PSOW.

Collaboration across and between Ombudsmen

10.1 We know from our own experiences that people do not live their lives in silos. Whilst they often come to bureaux about a specific issue, when discussing the problem with them we often find that they will have on average two or three different problems that might interrelate. This is also likely to be the case in respect of complaints, where more than one public sector agency may be involved. It is also possible therefore that there may be involvement from both devolved bodies e.g. local authorities and those who are not devolved, for instance the Department for Work and Pensions. Therefore there might also be value in giving specific consideration, given some of the discussions about closer working between Ombudsmen within the Law Commission

[6] The Law Commission (2011) Public Services Ombudsmen, LAW COM No 329, page 68
[7] Ibid, page 25
[8] Ibid, 30

review, to how the PSOW could collaborate or undertake joint investigations or reviews with other Ombudsmen and regulators in the future.

Time restrictions on making a complaint the PSOW

11.1 We would also highlight the issue of time restrictions within which someone can refer an issue to the PSOW, currently one year. We would suggest that particularly within the health service, this may make it difficult for people to make a complaint to the PSOW if they are not satisfied with the outcome through the internal complaints procedure of the health body in question. This is because whilst an individual has 12 months within which to make a complaint to a Local Health Board for instance, if an in-depth investigation has to be undertaken, it can take up to six months to complete this. This may mean (where an individual has waited some time before choosing to complain) by the time an in-depth investigation has been completed, they will be outside of the time limits to take a complaint to the PSOW. We would argue that it can take people time to make a decision to complain, particularly thinking about people who may have experienced an issue with their health and may be coming to terms with this. An individual in this situation may also have needed to take some time to focus on improving their condition. We would suggest therefore that consideration is giving to extending the time limit within which a complaint may be made to the PSOW about health services, to a year from the date of the outcome of the internal decision on their initial complaint to the health authority (such as a Local Health Board), in question.

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Care Council for Wales' response to the inquiry into the consideration of powers of the Public Services Ombudsman for Wales

The Care Council for Wales (Care Council) is the regulator of the social care profession in Wales. We register social workers, social work students, social care managers and residential child care workers, and investigate allegations received regarding their fitness to practise.

The Care Council is a listed authority in Schedule 3 of the Public Services Ombudsman (Wales) Act 2005.

We welcome the opportunity to respond to the inquiry.

Please see our comments to some of the questions imposed below:

- *Own-initiative powers – this would enable the Ombudsman to initiate his own investigations without having first received a complaint about an issue;*

1. We support the proposal that the Ombudsman is able to initiate his own investigations since we believe this will enhance the protection offered by the Ombudsman's office particularly to those more vulnerable members of society who may be more reluctant to initiate a complaint against public services.

2. We would suggest that if this power is provided to the Ombudsman, it will be essential that bodies such as ourselves work closely with him/her and that consequently consideration is given to the establishment of information-sharing protocols which would set out each organisation's responsibilities and which organisation should lead during an investigation, even though we are a listed authority in the Ombudsman Act. There is a good precedent for this as we have an information-sharing protocol in place with the Older People's Commissioner for Wales, even though we are a body reviewable under section 3 of the Commissioner for Older People (Wales) Act 2006.

- *Oral complaints - at present, the Ombudsman can only accept complaints in writing;*

3. We would support this proposal for the reasons outlined above.

- *Complaints handling across public services – this would enable the Ombudsman to have a role in advising on complaints handling across public services;*

4. We believe that greater consistency in approaches to complaints handling would be of benefit to the public sector in Wales and would therefore support this proposal. While we do not feel a standardised approach across the public sector is feasible or desirable, further consistency would be helpful particularly where a range of organisations may be dealing with the same complaint at varying points in time.

- *The Ombudsman"s jurisdiction (to include private health services) –this would extend the Ombudsman"s jurisdiction to enable him/her to investigate when a patient has received private healthcare (self-funded, rather than being commissioned by the NHS) in conjunction with public healthcare;*

5. We would support this proposal as a measure that would achieve greater equality of opportunity for investigation and possible redress for the range of mechanisms by which healthcare may be funded.

- *Links with the courts - the removal of the statutory bar to allow the Ombudsman to consider a case that has or had the possibility of recourse to a court, tribunal or other mechanism for review (this would give complainants the opportunity to decide which route is most appropriate for them).*

6. While in principle the Care Council would support this development, we would be concerned if this resulted in further delays in the time taken to resolve matters or delayed the time taken for complaints to the Care Council being able to be taken forward. We would wish further detail and assurance regarding the implications of such a development before wholly supporting such a change.

Care Council for Wales
4 March 2013

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Northern Ireland Ombudsman

Briefing Note on Evidence to Welsh Assembly – 5 March 2015

1. INTRODUCTION AND PREAMBLE

I am grateful to the Finance Committee of the National Assembly for Wales for this opportunity to comment on the inquiry into the potential legislative changes to strengthen the role of the Public Services Ombudsman for Wales (the Ombudsman). I welcome the proposals to strengthen the Ombudsman's role. That is because ombudsmen play an important role in the Administrative Justice Landscape providing redress for the citizen who suffers injustice and improving public administration through their recommendations and insights. The pillars of Administrative Justice for the citizen in Wales (as in Northern Ireland) comprise the decision making of public bodies (including their complaints handling processes), tribunals, the Ombudsman and the courts. It is interesting to note that the Finance Committee's inquiry spans major elements of this unique justice system (public sector complaints handling, ombudsmen's powers and the links with the courts). The importance of this inquiry therefore for the citizen and for the delivery of public services in Wales should not be underestimated.

As Northern Ireland Ombudsman, I enjoy a strong working relationship with the current Ombudsman, Mr Nick Bennett, and fully support his office in seeking to update the Pubic Services Ombudsman (Wales) Act 2005. I have enjoyed a similar working relationship with his predecessor, Mr Peter Tyndall (the current Irish Ombudsman and Information Commissioner), and with the Scottish Ombudsman, Mr Jim Martin. The strength of the ombudsmen community through the Ombudsman Association network should not be underestimated. This has enabled me and my staff to work closely and learn from devolved ombudsmen in Scotland and Wales as well as the Parliamentary and Local Government ombudsmen in England. When developing the policy platform for the changes in my own legislation, I was supported by this strong network and, in particular on the issue of an own initiative power, I was informed greatly by Mrs Emily O'Reilly (the former Irish and now European Ombudsman) in her approach to this important investigatory power.

Finally, this inquiry is timely as my own legislation is currently subject to deliberation by the Committee of the Office of the First Minister and Deputy First Minister (OFMDFM) of the Northern Ireland Assembly. My comments on the specific areas to be debated by the Finance Committee make reference to the OFMDFM Committee's deliberations on these issues and I attach a link to these legislative proposals:

http://www.niassembly.gov.uk/assembly-business/committees/office-of-the-first-minister-and-deputy-first-minister/legislation/northern-ireland-public-services-ombudsman-bill/.

At present, I await the introduction of a Bill into the Assembly to amend my existing legislation. I hope therefore that the Committee will find my evidence useful in their project to strengthen the Ombudsman's powers. It may be helpful to contextualise my views by explaining my current role and remit.

2. THE ROLE OF THE NORTHERN IRELAND OMBUDSMAN

In my role as Northern Ireland Ombudsman, I hold two statutory offices; Assembly Ombudsman for Northern Ireland and Northern Ireland Commissioner for Complaints. In the former role, I investigate complaints of maladministration about Northern Ireland Departments and their statutory agencies. In the latter role I can investigate complaints of maladministration about local government, health and social care, housing and education. My remit in health permits me to investigate complaints relating to the clinical judgement of health professionals in health and social care trusts, general health service and independent health services providers. In May 2014, I was given powers to investigate complaints about alleged breaches of the Local Government Code of Conduct for Councillors (the Code); and I have power to adjudicate or sanction where the Code has been breached. I have a statutory bar in both pieces of legislation underpinning my Office Article 10(3) of the Ombudsman (NI) Order 1996 and article 9(3) of the Commissioner for Complaints (NI) Act 1996. Currently, I can only investigate a complaint made

to me in writing and I have no power to commence an own initiative investigation.

Since 2009 complaints to my office have been increasing annually. The initial rise in complaints in 2009 was a result of the removal of the middle tier of complaints handling for health and social care (HSC) complaints. As a result of this change, complaints about HSC bodies are made to my office after a one stage complaints procedure. In the first year when this change occurred, there was an increase of 120% in complaints about HSC bodies. This upward trend has continued each year since and last year while complaints to my office increased overall by 31%. That upsurge was driven by a more than 46% increase in health and social care related complaints which include complaints about clinical judgment of health professionals. For the period 2011 to 2014, while complaints overall to my office have increased, complaints about central government departments in particular have decreased. Further, during the same period, I have upheld or partially upheld complaints about public services in Northern Ireland (on average) in 55 % of cases.

3. OWN INITIATIVE POWER

I have invited the OFMDFM Committee of the Assembly to include this power in the new legislation which is currently under development. The proposal for my Office to have this power was first initiated as a result of the independent review of my Offices (the Deloitte Review 2004). That review included an examination of other ombudsmen's jurisdictions internationally such as Canada and New Zealand where the ombudsmen traditionally have been provided with this power. It is interesting that the Irish Ombudsman has enjoyed this power since its inception in 1980 and the European Ombudsman utilises this power to effect administrative improvements.

Having regard to its effectiveness in other jurisdictions, I strongly believe that this will be an important power in the Ombudsman toolkit. I am therefore pleased to record that the OFMDFM Committee has included this proposal in their draft Bill.

It is an important power in circumstances where an individual does not have a voice or cannot complain due to vulnerability or a misgiving as to how they will be treated. I have given evidence to the OFMDFM Committee to the effect that this power should be exercised sparingly at the ombudsman's discretion and that decisions should be evidence based. In Wales, the Ombudsman currently has power to publish his reports in the public interest. My office has undertaken research on the international experience of own initiative investigations. That research demonstrates that these inquiries will often be matters of public interest that demand a level of public scrutiny.

I note the Committee is interested in views as to how this power can be managed in order to avoid duplication and overlap with the role of other oversight bodies. The Deloitte review of my office recommended that a decision to commence an own initiative investigation should be made after consultation with the Comptroller and Auditor General for Northern Ireland so as to ensure that there was no overlap in remit. It is important that this power should not be exercised where another oversight body has a similar remit without prior consultation and liaison with that body. It is for that reason that the OFMDFM Committee are proposing consultation and information sharing powers with other devolved Ombudsmen and commissions in Northern Ireland as well as the Irish Ombudsman to avoid duplication. I note that the Ombudsman has a Memorandum of Association with the Children's Commissioner and the Older Person's Commissioner for Wales. This is an example of good practice and I consider the use of such Memorandums of Understanding promote more effective working relationships among scrutiny bodies and help ensure more efficient use of investigation resources.

Research has highlighted a number of potential models for Own Initiative investigations and my Office has shared its research on this issue with the Ombudsman and his staff. In Ontario for instance the Own Initiative model of SORT (Special Ombudsman Response Teams) was created by the Ombudsman to carry out investigations of **serious, systemic** issues that are matters of significant public interest. SORT investigations involve extensive field work,

interviews and evidence gathering, and generally result in a published report. Individual complaints are also investigated and if a complaint raises a serious issue that complaint may be a trigger for a SORT investigation.

The extent of cost savings and financial resources depends on the particular model to be adopted by the Ombudsman. A decision making tool can be developed to assist in deciding whether there is evidence of systemic maladministration based on a single or multiples complaints. An own-initiative model that permitted joint investigations with 'specialist' scrutiny bodies such as a Human Rights, Children's or Older Person Commission could save on the costs of investigation for the offices concerned. Joint working is often a more effective model as it could permit the Ombudsman to have the benefit of specialist expertise in cases involving a particular group such as children or the elderly. An alternative model could be developed that would focus on the body or bodies seeking to resolve existing complaints as part of its internal complaints procedure on foot of an Own Initiative report. This model could save the additional costs of the Ombudsman investigating individual complaints on the same issues as the Own Initiative investigation and save costs to the public purse overall. The latter model has the advantage of encouraging bodies to seek early resolution of complaints and take ownership of issues, an approach which I will return to later in my evidence to the Committee.

4. ORAL COMPLAINTS

Currently, I can only accept a complaint in writing. It is important that the Ombudsman has a discretion to accept a complaint in any form and any barrier to communicating a complaint can be an access to justice issue, particularly for those with literacy difficulties.

As highlighted previously, the OFMDFM Committees proposals to change my legislation do include provision in the draft Bill for the acceptance of oral complaints. However, I am mindful of the practical challenges of this inclusive approach. In particular it is important that at some point the Ombudsman's

staff will have to commit an 'oral' complaint to writing. This is essential in order for staff to clarify issues of complaint with the complainant so as to enable the Ombudsman and his staff to decide the issues that he will investigate.

An interesting trend that is currently emerging in Northern Ireland is the use of social media to 'tweet' complaints to bodies in my jurisdiction. I have already had a request from one public body for advice as to how to deal with this emerging issue. I would urge caution in this regard although I am aware that in seeking to provide our services to children and young people, the ombudsmen community should be aware that social media is the preferred mode of communication for today's youth.

My personal view is that the use of social media to make a complaint does raise issues of privacy and confidentiality. Presently my Office accepts confidential complaints in writing, by email, in person or through my website by use of an online complaints form only. My office does not have a Facebook or Twitter account at present. There is a risk attached to the acceptance of complaints through these social media mechanisms because they are not confidential.

5. COMPLAINTS HANDLING ACROSS PUBLIC SERVICES

At present there is no Complaints Standards Authority (CSA) in Northern Ireland as there is in Scotland. The OFMDFM Committee did consider this additional role for my Office as part of its development of the new legislation and decided it was not an appropriate model at this time.

The addition of a CSA type role for my office was raised as part of the public consultation on the proposals for legislative change in September 2010. The OFMDFM Committee did consider the responses to that consultation and my views and decided that this was not an appropriate model. In the absence of support for this model in Northern Ireland, an alternative approach has been developed. Building on the work of the PHSO on the Principles of Good

Complaint Handling, and in particular the Welsh model complaints policy, my Office produced a guide to effective complaints handling entitled 'Rights, Responsibilities and Redress' which can be found at the following link: http://www.ni-ombudsman.org.uk/niombudsmanSite/files/94/94a67a87-bb5d-4392-9e6a-359a438596b6.pdf.

I am pleased to record that the Principles of Good Complaint Handling and good practice in other jurisdictions reflected in my publication were adopted by the Northern Ireland Civil Service (NICS) for all Northern Ireland government departments and their statutory agencies in 2014. This work has resulted in standardised complaints policies across NICS Departments and agencies. The 'softer' approach than that of a complaints enforcement body is of benefit as in my view it encourages bodies to take ownership of the complainants issues. As a result of this NICS initiative, led by the Head of the Civil Service in Northern Ireland, Dr Malcolm McKibbin, there has been a reduction in complaints about government bodies to my Office.

However, I do see merit in a model complaints procedure and the sectoral approach. The CSA model supported by training for bodies in remit has been an undoubted success in Scotland. That model has achieved much uniformity in approach across sectors with a small but dedicated team of SPSO officers. It is noteworthy that the Scottish model has been successful at low cost. However, there remains an issue of how far the enforcement model can extend in the event of non-compliance. It may be that ultimately the Parliament or Legislative Assembly is the forum for ensuring compliance with the CSA model. The power of the political process to support the Ombudsman in carrying out his statutory functions is an important theme that I will return to later in my evidence.

It is my view that there are financial savings to be achieved in adopting a common streamlined model of complaints handling. A multi-tiered complaints handling procedure can be costly to maintain for the public service provider, it is resource intensive and can be overly bureaucratic. Ultimately this can lead

to the complainant feeling overwhelmed and not pursing the complaint further.

6. OMBUDSMAN'S JURISDICITON IN PRIVATE HEALTH CARE

I consider that currently the Ombudsman has a wide jurisdiction to investigate complaints of maladministration about public services, including private services commissioned by the NHS. I have a similar jurisdiction as the principle of 'follow the public pound' applies. However, unlike the Ombudsman, I do not have jurisdiction to investigate complaints about privately funded social care.

Where the service to the citizen is paid for by the public purse then, in my view, a Public Service Ombudsman should investigate complaints about the publicly funded service regardless of the identity of the provider. However, I do not consider that the Ombudsman's jurisdiction should extend to privately funded health care. That is because the individual has other routes to remedy though consumer advocacy groups such as the National Consumer Council and through the courts by way of an action for damages for negligence of breach of contract. Further, the ADR Directive that will be transposed into UK law later this year does make specific provision for an ADR mechanism for consumer disputes. I consider therefore that this aspect of redress for the citizen who exercises the choice to utilise private health care provider as opposed to a public health care provider is not disadvantaged because he/she cannot have recourse to a public services ombudsman.

There is also an issue about the public purse resourcing the ombudsman to investigate complaints about the private sector in the context of a shrinking public sector budget. If the Welsh Assembly were to adopt the proposal for the Ombudsman to have this public and private sector dual function, how will this reflected in government accounting terms if the private sector element of the Ombudsman's work were to be paid for on the 'polluter pays' principle by way of levy to the sector or the service provider.

Public Service ombudsmen recommend remedy where they find maladministration or service failure. This mode of redress is largely successful within the public sector because of the power of the political process to ensure compliance through holding public bodies to account. The power of 'moral suasion' operates effectively in this context but may not be as effective in the private sector context as compliance may be harder to secure. It is important to note that private sector ombudsman such as the Financial Services and Pensions ombudsmen's decision are legally binding perhaps for this reason.

7. LINKS WITH THE COURTS

In 2011, the Law Commission for England and Wales identified a number of areas for legislative change. These recommendations included the removal of the statutory bar on alternative legal remedy; a power of the Administrative Court to stay cases and refer them to the Ombudsman with a discretion on his/her part to accept a case for investigation; and the ability for the ombudsman to refer a case to the court on a point of law.

As part of the development of my new legislation in Northern Ireland, these proposals were considered by the OFMDFM Committee and by myself. That Committee did not consider that the Law Commission proposals were suitable in the Northern Irish context. I personally take the view that it is important that there is a clear demarcation between the work of the ombudsman and the courts. I consider that in the new Northern Ireland legislation the statutory bar should remain with the existing proviso which allows the ombudsman to consider a case where a legal remedy exists but it is not reasonable to expect a complainant to pursue or have pursued that remedy. Case law suggests that in circumstances where the complainant cannot pursue a legal remedy because of the issue of resources that the ombudsman can accept a complaint for investigation.

In addition, in Northern Ireland a number of pre-action protocols have been developed for the courts informing the parties of the existence of my office and other ADR mechanisms. This practice allows the parties to choose to

which forum to bring their administrative dispute, the court or the ombudsman. There is more generally a trend in Northern Ireland supported by the courts to encourage mediation to resolve disputes. It is important to view this change in approach to dispute resolution having regard to the cuts in legal aid budgets and overall pressures on the public purse.

In relation to the suggestion that the Ombudsman should have power to seek a declaration of illegality from the courts, this can be a useful mechanism to resolve issues of legal interpretation. My only concern is who in the present economic climate will meet the costs of this litigation

I am happy to expand on these views at the evidence session on 5 March 2015.

Dr Tom Frawley CBE
2 March 2015

Northern Ireland Ombudsman

A PAPER PREPARED BY THE OFFICE OF THE NORTHERN IRELAND OMBUDSMAN ON A POWER TO COMMENCE AN OWN INITIATIVE INVESTIGATION

January 2014

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1. Introduction

1.1 The Northern Ireland Ombudsman (the Ombudsman) welcomes the proposal by the OFMDFM Committee of the Northern Ireland Assembly to create a new office of a Northern Ireland Public Services Ombudsman (NIPSO), with a power to commence an investigation on his own initiative. The purpose of this paper is for the current Ombudsman to provide detail and clarification of how the proposed power might be exercised and to provide examples of when, in his view, the own initiative power could have been applied in recent years and whether if the power had been available to him the likelihood it might have offered a more efficient and effective use of available resources. The Ombudsman's office in this paper provides some examples of cases where he considers an own initiative authority would have facilitated a more comprehensive and complete scrutiny of the matter being investigated. The examples included in this paper are only by way of illustration and the Ombudsman is mindful that the new NIPSO will be making such decisions on his/her own account in the context of new legislation and an expanded remit and powers.

1.2 It is noted that '*during the drafting of the NIPSO Bill, the Committee will take advice more generally on the options to require NIPSO to evidence the reasons for the own initiative inquiry*',[1] for example giving notice to the body or sector to be investigated. The Committee's proposals for this power include the need to address the issue of potential overlap with the role of other investigatory bodies. The Committee is proposing that the NIPSO will be accountable to a Committee of the Assembly in relation to the proposed budget for, and actual expenditure on, own initiative investigations. In this paper, the Ombudsman's office sets out a view on how this accountability might operate in practice. The issue of how an own initiative team within the office of the proposed NIPSO might be resourced has already been addressed by the Ombudsman and two

[1] Committee for the Office of the First Minister and deputy First Minister, Report to the Northern Ireland Assembly , 16 September 2013

distinct costing models provided[2]. For ease of reference a copy of the costing model is attached at Appendix 1.

1.3 The Ombudsman welcomes the Committee's continued work and support in development of the NIPSO Bill which, when enacted, he believes will provide the citizens of Northern Ireland with the most modern and effective redress mechanism for administrative failures in the United Kingdom. The Ombudsman and his staff for their part are committed to providing any further information or clarification on the issues in this paper, that Committee members consider would be helpful.

2. Background

2.1 The Ombudsman Concept[3]

'Ombudsman' is a Swedish word meaning trusted official, and it was in Sweden in 1809 that the first ombudsman was appointed by the then King of Sweden. The Danish Ombudsman's office was established in 1955 and in 1962 the first ombudsman office in the Commonwealth was introduced in New Zealand. The first Ombudsman appointed in the United Kingdom was the Parliamentary Commissioner for Complaints, brought into being by the Parliamentary Commissioner Act 1967 and Northern Ireland was the first region in the UK to have an ombudsman, the office being created in 1969 by the Stormont Parliament. Since its inception, the role of the ombudsman has been to independently investigate citizen's complaints about civil administration. The Committee may find the following descriptions of what the traditional or classical ombudsman schemes can provide a helpful context for their discussion on how an own initiative power might be applied, while always being mindful of the unique role that an ombudsman offers; an alternative to the courts in providing citizens with recourse and remedy through proportionate redress for administrative failures.

[2] Northern Ireland Ombudsman, Assembly Ombudsman for Northern Ireland and Northern Ireland Commissioner for Complaints Legislative Reform Costing Model Supporting Documentation, June 2013
[3] Mary Seneviratne – Ombudsman, Public Services and Administrative Justice 2002 Butterworths: Law in Context

'*An office provided for by the constitution or by action of the legislature or parliament headed by an independent, high level public official who is responsible to the legislature or parliament, who receives complaints from aggrieved persons against government departments, agencies and officials and employee or who acts on his own motion, and who has the power to investigate, recommend corrective action, and issue reports"*[4]

An ombudsman has also been described as:

'*A reliable person who, for purposes of legal protection of individuals as well as parliamentary control, supervises almost all administrative bodies and civil servants. He cannot correct their decision but – based on submitted complaints or own initiatives – he may criticise them'.*[5]

This second definition recognises the important dual role of the ombudsman as a protector of the rights of the citizen and also an officer of the legislature who examines the performance of public services provided by the Executive through its Departments, their agencies and public bodies.

2.2 The traditional model of Ombudsman, it is accepted, has always included an own initiative authority. In the Council of Europe, only the UK Ombudsman and half a dozen other countries[6] do not have own initiative powers. Those ombudsmen who do have the power use it responsibly but with positive effect. For instance, the Swedish Ombudsman reported in 2009 that the use of own initiative investigations resulted in adverse findings against public bodies in 80% of cases investigated where there had been only 10% adverse findings in those cases where individual cases brought by complainants were investigated. The academic study of own initiative powers conducted by Buck et al[7] in 2011

[4] W Haller 'The place of the ombudsman in world community' (1988) Fourth International Ombudsman Conference Papers p29
[5] Hansen 'Die Institution des Ombudsman' (1972) Athenaum Verlag p2 Referred to and translated in K Heede 'European Ombudsman: redress and control at Union level' (2000) Kluwer Law International p8
[6] Belgium, Israel, Luxembourg, Azerbaijan, Kyrgyzstan, and Liechtenstein (source Nick O'Brien's unpublished paper on own initiative powers)
[7] The Ombudsman Enterprise : Kirkham, Buck and Thompson (2011)

recommended that a '*full own initiative power allied with better co-ordination with auditors and other integrity bodies would assist ombudsman bodies further to play to their existing public service strengths'.* It is noteworthy that the Deloitte Review of the Office of the Northern Ireland Ombudsman (2004) recommended that the office should have a power to conduct an investigation or systemic review on its own initiative caveated only by the condition that an own initiative investigation should be undertaken following consultation with the C&AG.

2.3 More recently, the Parliamentary and Health Service Ombudsman, Dame Julie Mellor, gave evidence to the Public Administration Select Committee (PASC) at Westminster, seeking own initiative powers, basing her case for such a power on the need to provide access to justice for the most vulnerable, who are least likely to find or gain access to the services of an ombudsman[8]. In Northern Ireland, the present Ombudsman supports Dame Julie's view that the use of own initiative should be evidence based and that, for example, it could be used to provide a voice to those who are unable for reasons of being marginalised, disabled or vulnerable to bring a complaint. In making her case for an own initiative power Dame Julie emphasises that in areas such as incapacity benefit and child support, such a power: '*Would mean we could intervene early and prevent expensive escalation of complaints by sorting something out for the whole group, but it also prevents mistakes being repeated by being able to give a systemic remedy...the own initiative power would enable us to be better value for money, because we would be able to apply remedies to much wider groups of people, and that builds confidence in the whole complaints process'.*

2.4 It is noteworthy that particular reference is made in the Committee's deliberations on these issues on the need for an evidence base to inform a decision to initiate an own initiative investigation and this point has also been highlighted by the PHSO. Against the background of a heightened interest in the UK in own initiative powers, it may be helpful to the Committee if examples

[8] Hansard Oral Evidence: Parliament's Ombudsman Service HC655 at Q216

of the benefits to citizens arising from the use of such a power in other jurisdictions are identified (see section 3 below).

3. The Use of Own Initiative Powers in Other Jurisdictions

3.1 Some limited research has been undertaken by the Ombudsman with the purpose of providing information on the types of evidence that has been used to support a decision to commence an own initiative investigation in other jurisdictions, in particular Ireland, Canada (Ontario) and Malta. Although in Malta where, media reports have been the prompt for these type of investigations, the research suggested a trend that warranted an own initiative inquiry was usually related to the receipt of one or a number of complaints to the ombudsman.

Ireland

3.2 The background to own initiative in Ireland is illustrated by the table below which sets out the prompts associated with a number of own initiative investigations undertaken by the Irish Ombudsman. On 15 June 2011, the Committee will recall it heard from the then Irish Ombudsman, Mrs Emily O'Reilly, as to the occasions in the Republic of Ireland where she or her predecessors have used the own initiative power under Section 4(3) (b) of the Ombudsman Act 1980. These provisions confer a broad discretion and there are no limitations on when that power may be used. Over the period 2001 to 2010, there have been a total of 5 own initiative investigations on issues ranging from subventions in nursing home care, the failure to provide full refunds of tax to widows in receipt of public service occupational pensions,[9] to investigations into the right to nursing home care for older people[10]. The table below illustrates an outline of each of these own initiative investigations and highlights the triggers for the investigation and the impact or outcome of the investigation.

[9] 'Redress for Taxpayers (published 2002)
[10] 'Who Cares'(published 2010)

Date	Subject Matter	Linked to a complaint or complaints	Outcome
2001	Payment by health bodies of nursing home subventions	> 150 complaints	Government refund of €1.5 billion to families affected.
2002	Refund of tax to widows in receipt of occupational pensions	2 complaints	Refunds of €3.8 million
2006	Overcharging of in-patient nursing home services	1 complaint	Refund of €1,126 to complainant. Refund of €131,000 to 51 other families similarly affected
2008	Local authority waiver scheme for refuse collection charges	3 complaints	National review by department of waste management policies
2010	Right to long term nursing care for elderly	1200 complaints over 25 years	Report Not accepted by bodies

It has not been possible to ascertain if there were costs savings or efficiencies achieved in the Irish Ombudsman's budget as a result of these inquiries. However, there is clearly a significant impact or benefit to citizens. With the exception of the Who Cares report (2010), the impact of these investigations is much wider than the individuals who brought the issue to the Ombudsman. The Oireachtas has now established an Oversight Committee dedicated, among other things, to considering Ombudsman reports but it was not in place when the Who Cares Report was issued. Ms O'Reilly referred to the report, as follows, when she appeared before the Oversight Committee for the first time on 20 July 2011:

'Some other reports may deal with matters of significant public interest which I choose to bring to the attention of the Oireachtas and-or the public generally - for example, the Who Cares? report which I published in late 2010, just some months before the dissolution of the previous Dáil. This investigation looked at the actions of the former Department of Health and Children and of the Health Service Executive. It was based on 1,200 complaints received by my office over 25 years relating to the failure of the health boards and later the HSE to provide for older people in public nursing homes with the result that many had to avail of expensive private nursing home care. The report attracted considerable media attention but again I was disappointed that it was not considered by an Oireachtas committee.'[11]

3.2 The Irish Ombudsman has a protocol which commits the Office to notify the relevant Minister/Department or the Chief Executive of the body that will be the subject of an own initiative investigation. The notification letter specifies the legal basis for the investigation, the prompt or reason for the investigation and its scope or terms of reference. The notification also includes a request for access to records and information relating to the issues which are to be the subject of the investigation. This is a practice which, as outlined later in this paper, the NIPSO may seek to replicate if the own initiative power is included in the legislation enacted by the Assembly to bring the new office of the NIPSO into being.

Canada (Ontario)

3.3 Section 14(2) of the Ombudsman Act 1990 provides the Ontario Ombudsman with a discretionary power to investigate a complaint from any person or to investigate on 'his own motion'. There are no limitations on that discretionary power. Since 2005 the Ontario Ombudsman has reported on 30 systemic investigations led by the Special Ombudsman Response Team (SORT). This team was created in 2005 to conduct systemic investigations on high-profile issues affecting large numbers of people. These investigations are conducted only where the Ombudsman is satisfied that there is sufficient evidence to

[11] Oireachtas - Orders of Reference of the Joint Committee – Discussion with Ombudsman 20 July 2011

warrant an investigation. There are clear criteria for these systemic investigations:

- there is a serious and sensitive issue with a high public interest dimension;
- there are broad systemic implications;
- the facts of the complaint are complex and/or not agreed upon and;
- there is no likelihood of an informal resolution to the complaint.[12]

3.4 Like the Irish Ombudsman, the Ontario Ombudsman's investigation is usually triggered by one or multiple complaints to his office. It is his practice to publicly announce his intention to conduct a SORT investigation and to call for other complaints or cases to be brought to his office. The investigation findings and recommendations are reported on publicly and the report is presented to Ontario's Legislative Assembly. These reports can focus on a wide range of issues. For instance the Ontario Ombudsman has completed investigations and reported on a diverse range of issues including services available for adults with developmental difficulties (2012), the use of force in jails (2013), the monitoring of unlicensed day care (2013), and the limited funding available for the drug herceptin for patients with breast cancer (2011).

3.5 The issue of providing those who may be unable to make a formal complaint due to their perception of the potentially adverse consequences for their relative or friend in the care setting is highlighted by the Ontario Ombudsman's report 'Between a rock and a hard place'. In the concluding paragraph of Andre Marin's report into the plight of parents who were forced to place their severely disabled children into the care of Children's Aid Societies in order to secure the essential support their children needed, he reports on the palpable fear of the parents of the potential consequences of coming forward to his office to complain.[13] This can sometimes be the case in institutional care settings and thus this is the sort of circumstance where an own initiative investigation can

[12] www.ombudsman.on.ca
[13] www.ombudsman.on.ca/Investigations /SORT-investigations (May 2005 at paragraph 164, page 42)

provide a 'voice' to those who either are frightened or due to vulnerability or disability are unable to complain.

Malta

3.6 The Ombudsman Act 1995 provides the Maltese Ombudsman with a broad discretionary power to investigate the administrative functions of a body in his remit on his own initiative[14] or where he receives a complaint from a person aggrieved by such actions. There is no statutory limitation on this power but it is noteworthy that he will exercise this power where there is a 'substantial public interest and importance are concerned'.[15] In addition, any Committee of the House of Representatives may refer any matter that is under consideration by it to the Ombudsman for investigation. The Prime Minister may also at anytime refer a matter for investigation by the Ombudsman which the Prime Minister considers should be investigated.

3.7 A limited examination of the own motion investigations of the Maltese Ombudsman (whose jurisdiction includes the University Ombudsman for Malta) has disclosed that own initiative investigations can be prompted by a complaint from an individual who has experienced maladministration, public debates on current public interest issues, a media report or from the Ombudsman's experience of investigating other issues in a particular sector. For example, in 2012 the Ombudsman's annual report makes reference to the commencement of an own initiative investigation into waiting lists for outpatient appointments in two Maltese hospitals and government health centres. This was prompted by ongoing public debate. An article in The Maltese Times on 6 November 2012 was the trigger for an own initiative investigation into the delay in obtaining appointments for babies and children with hearing difficulties[16]. In 2007 the Ombudsman published a report of an own motion investigation relating to the legislation and policies regulating requests for revision of papers and/or verification of exam scripts. This investigation was commenced as a result of the Ombudsman's experience of complaints regarding the outcome of selection

[14] Section 13(2) of the Ombudsman Act 1995
[15] www.ombudsman.org.mt/index.asp?
[16] Office of the Ombudsman Annual Report 2012 at page 80

procedures for posts in the public sector. In that investigation a number of institutions in the public sector were asked to provide details of legislation, policies and practices in this area which included the University of Malta, the Malta College of Arts, Science and Technology, the Education Division, the Institute of Tourism Studies and the Public Services Commission. The Ombudsman, Dr Pullicino, in another case, recommended a review of policies by those organisations that did not have in place any or adequate access policies, through which the criteria against which examinations scripts are to be marked are properly established by regulation and where examiners do not put their comments on the actual scripts and ensures that the documents on which these are recorded are accessible to candidates. This example again highlights the value that broad based own initiative investigations can bring to a greater number of citizens.

3.8 The Maltese Ombudsman has also a responsibility to oversee that the conditions and circumstances in which refugees from Africa are accommodated on the island meet Human Rights, European Council and UN standards. Following an inspection visit to a holding centre he decided to invoke his own initiative authority to review the total management system and facilities allocated to meet this sensitive statutory responsibility in Malta.

3.9 It is hoped that this brief overview of three separate jurisdictions is useful in highlighting the range of potential prompts for own initiative investigations as well as the diverse range of issues that may be covered by such inquiries. What is clear from this limited research is that in each instance there is some evidence base for the investigation although that evidence may derive from a number of sources including complaints received by the Ombudsman, wider societal debate and/or media articles. The value to a greater number of citizens has been demonstrated, in particular the financial benefits to members of the public are evident in the cases from Ireland. However, it has not been possible to obtain data on the extent to which in each jurisdiction these investigations have resulted in efficiencies or cost savings.

4. Conducting Own Initiative Investigations – Some Considerations

4.1 The Committee seeks clarification as to how the NIPSO might approach the conduct of own initiative investigations. The Committee has already indicated its expectation that a decision to commence an own initiative investigation should be evidence based. The Ombudsman agrees with this approach and in this section will explain his views on an appropriate and proportionate approach to this power. The Ombudsman considers that in approaching the decision to commence an own initiative investigation, the NIPSO should be guided by to the Principles of Good Administration[17] :

- **Getting it right**
- **Being customer focused**
- **Being open and accountable**
- **Acting fairly and proportionately**
- **Putting things right**
- **Seeking continuous improvement.**

In this regard it will be important for NIPSO to have a clear, publicly available statement on his or her approach to own initiative that reflects these principles. Further, the Ombudsman currently has a policy which he has developed to allow him to make decisions on which complaints, given the ever increasing number of cases brought to him, he will investigate. A copy of the Validation and Investigation Criteria policy is attached at Appendix 2 and it is worthwhile considering the application of the principles of public interest, proportionality and practical outcome when addressing the issue about which the NIPSO might investigate if an own initiative power were available.

4.2 The Committee's policy proposal is that the NIPSO have an own initiative power where he or she believes there is systemic maladministration. There has been a tendency to use the phrase 'systemic' and 'own initiative'

[17] www.phso.gov.uk

investigation interchangeably, despite there being some subtle yet important differences between these two 'types' of investigation.

The fundamental difference lies in what prompts the investigation, and thereafter who will be the subject of the investigation. Systemic investigations are usually initiated as a result of a complaint having been received. This can be one complaint or a number of complaints about the same issue which may point to a trend or pattern that is worthy of investigation. Ultimately, therefore, a systemic investigation is one that goes beyond the immediate issue raised by a particular complaint to identify if it is symptomatic of a much bigger problem. Thereafter, the focus is on addressing the underlying cause and recommending changes that will offer both remedy for the individuals affected and address the causes of the problem.

4.3 A broadly based power to commence an 'own initiative' investigation (as is provided for in Ireland, Malta and Ontario) is more encompassing than a power to simply investigate systemic failure and can be used effectively in a variety of circumstances including the investigation of an individual high profile case; the investigation of issues which were the subject of a complaint or a number of complaints; the investigation of a sector or across sectors on a theme such as dealing with homelessness issues, delivering care in a non-health related environment such as prisons or sheltered accommodation, the experience of adults with learning difficulties in institutional care. There are a wide range of circumstances which could prompt an 'own initiative' investigation by the Ombudsman. These include, as has already been indicated, evidence gathered through the NIPSO casework/research, evidence gathered by another agency or regulator, by the legislature or a committee of the legislature, or prompted by a specific public debate or concern. Despite the wide level of discretion implied by the term 'Own Initiative' in reality the decision to initiate an investigation, on this basis, would as the Committee has concluded require to be **evidence based**, **reasoned, proportionate** and represent a **prudent use of public funds.**

4.4 In summary there could be a number of triggers for an own initiative investigation which the NIPSO could consider, these include:

(1) A complaint or series of complaints about a particular or similar issue;
(2) The Ombudsman's perception of significant public concern about an issue;
(3) The outcome of the Ombudsman's research on the issue;
(4) A media report;
(5) An organisation's own internal governance arrangements and external audit, having highlighted an issue;
(6) Report or reference from another oversight or integrity body;
(7) Identified as a result of scrutiny by a Committee of the Legislature.

4.5 In light of the experience of other jurisdictions the Ombudsman believes that NIPSO should *initially* focus its own initiative investigations on issues which are evidenced from existing or previous complaints to the office, so as to establish a track record of experience and expertise in undertaking such inquiries.

5. Deciding whether to conduct a Systemic/Own Initiative Investigation[18]

5.1 As indicated above, central to the effective use of any power that may be given to conduct an own initiative investigation is the evidence base that will inform the decision on what area of public service will be examined and what issues will be focused on. These decisions when taken must be demonstrably open, transparent and consistent. A decision framework template has been developed by the current Ombudsman (Appendix 3) which should assist the NIPSO in documenting in a systematic way the detailed reasoning that informed his/her decision to undertake an own initiative investigation. The template may also be helpful in explaining what has and what has not been considered and decided on before an investigation is commenced. The key matters covered are:

[18] Jones, G. (2009) Conducting Administrative, oversight and Ombudsman Investigations Pg 55

1. A summary of the issues to be investigated;
2. The source(s) of evidence identified in specifying that issue;
3. Jurisdictional issues that need to be understood and worked through in the investigation;
4. Interface(s) with other agencies or integrity bodies;
5. A summary of any evidence, readily available, of outcomes/decisions reached by other complaints mechanisms in relation to the area/issue proposed for investigation; and
6. A summary of any evidence the Office has already gathered on the issue including any evidence which suggests the level of, or potential for, recurrence of the issue.
7. Clarification of any action taken by the office or another body or Agency on the issue.
8. Assessment of each of the issues using the criteria outlined in the validation and investigation policy.

5.2 The Committee is concerned that any use of resources should be efficient and not detract from the core focus of the office which is the investigation of individual complaints. There will be a need to use NIPSO resources initially to establish whether or not an investigation should be undertaken. Consideration should be given to other alternatives to undertaking an own initiative investigation such as informal resolution. As part of the process of building an evidence base to inform whether an own initiative inquiry is appropriate, the NIPSO will need to liaise with other investigative agencies to ensure there is no potential duplication or overlap of inquiries with the proposed inquiry. Indeed, there could well be opportunities to use the expertise of other bodies in support of a NIPSO own initiative investigation. For instance if the issues concerned elderly or children's care homes, resources and expertise from the Older Persons, Children and Young Persons Commissioner and the Human Rights Commission could be requested, depending on the issue to be examined. The decision whether an own initiative investigation is warranted, may also involve informal contact with the relevant bodies and complainants to obtain the necessary detail and information on the issues of complaint.

5.3 Undoubtedly experience elsewhere suggests that launching an Own Initiative investigation can give rise to an increase in the number of individual complaints about the subject matter being examined. These individual complaints might also be proactively sought by the NIPSO as an agreed part of the strategy developed to investigate the issue being examined. A question around whether an Own Initiative report could also address more specific and particular individual complaints will also require to be considered. The custom and practice in other Ombudsman Offices undertaking work of this nature is that any individual cases of complaint received, regardless of whether they have been received in response to a systemic investigation being launched, are not investigated separately. There may still be a resource implication however limited, in directing individuals to the systemic report where their specific issues of complaint are adequately covered and, thereafter, pursuing any outstanding issues as necessary such as individual redress. Thus it is difficult to project the extent of any saving in the NIPSO budget arising from these inquiries. A key element of own initiative investigations is the follow up to ensure recommendations have been met and while this has resource implications it does help in the evaluation by NIPSO of the impact of the use of the power. This is a matter NIPSO should be reporting on publicly and could form part of any scrutiny.

6. Reports of an Own Initiative Investigation

6.1 Own initiative investigation reports should be publicly available documents given the significant public interest issues they are intended to address. There is currently a proposal for a statutory provision within in the NIPSO legislation for a power to publish any report of an investigation that is considered by the NIPSO to be in the public interest. The current Ombudsman considers that this power should extend to own initiative investigations.

6.2 At section 1 of this paper, the important role of the Ombudsman acting on behalf of the legislature to examine the experience of individual citizens of

services provided by Government Departments and public bodies is referred to. Consideration should therefore also be given to the laying of the own motion report before the relevant statutory Committee of the Assembly where adverse findings are made. For example, a health related report should go to the heath committee, environment report to the Environment Committee etc. Further awareness raising by NIPSO of the areas being scrutinised and recommendations in reports in addition to the detailed scrutiny of the issues by the Assembly or the relevant Assembly Committee, to ensure that matters of public interest are properly and effectively addressed by the bodies who are the subject of such scrutiny would also be important. The Committee may wish to consider developing a procedure to signpost the submission of completed reports to Assembly Committees under Standing Orders.

6.3 The Ombudsman considers that complainant's identities should not be published to protect the privacy of those individuals. However, there may be occasions where the public interest requires that officials who have been engaged with the investigation should be identified. Any decision to disclose the names or identities of such officials should be considered on a case by case basis, having regard to the views of those individuals, the public interest and the implications for the principles of openness and accountability. Where practicable a privacy impact assessment[19] should be undertaken by NIPSO, which would take into account the competing interests of personal privacy and accountability as well as the context and sensitivity of the issues being reported on.

7. Accountability

7.1 It is clearly essential for the NIPSO to account for the use of resources on all investigations including those that are commenced on 'an own motion authority'. However it is also important that NIPSO is independent and there is a clear need for objectivity to be demonstrated in any decision on whether or not to raise an own motion investigation. The decision ultimately must be that

[19] See ICO guidance on Privacy Impact Assessments (2013) at www.ico.gov.uk

of the NIPSO and must not be subject to political interference or influence. The proposal that the Audit Committee is an appropriate committee for the NIPSO to report to on performance and use of resources is welcomed. As part of that reporting cycle, NIPSO should also be asked to explain the application of resources on any own initiative investigation taken during the financial year being accounted for. Clearly it is for the Committee to decide whether the NIPSO has demonstrated the effectiveness and value of the investigations he/she has undertaken.

8. Possible Areas for Own Initiative – Examples from Completed AOCC Investigations

8.1 As indicated in 7.1, it is important that the NIPSO should have significant discretion in making the decision on whether or not to commence an own initiative investigation. By way of illustration the current Ombudsman highlights below a number of cases where an own initiative authority would have been in the public interest and allowed the Ombudsman to provide redress or assurance to a greater number of citizens.

8.2 In 2011, the Ombudsman concluded an investigation into 'charging' by North Down Borough Council for the disposal of household waste where there was no authority to levy a charge. The Ombudsman investigated the individual complaint and the complainant received a refund and redress for the injustice experienced by him. If the office had at that time the benefit of an own initiative authority, the Ombudsman could have commenced an own initiative enquiry to examine the charging policy of all other Councils in Northern Ireland. The local government auditor has subsequently referred to this case in her annual report. The benefit of such scrutiny would be to ascertain if the charging policy complained of represented a more widespread practice that was impacting adversely on ratepayers across Northern Ireland.

8.3 Planning is an issue that has been in the top three areas of complaint to the Ombudsman for several years and the wide range of issues that complaints about the planning service have been highlighted in successive annual reports. They include poor record keeping, failure to give adequate reasons for decisions and inconsistency in decision making. In 2012, the Ombudsman concluded an investigation into a complaint about the failures by the DOE Planning Service to take enforcement action against the breach of a planning condition by a licensed quarry company in Co Tyrone. The complaint highlighted deficiencies in planning enforcement policy and the absence of a proactive approach to enforcement by the Planning Service. A further issue identified was the inconsistency in the approach to enforcement policy across the province which has been highlighted by a number of other complaints to my office. Again, an own initiative investigation into the failings as identified in previous Ombudsman investigations could benefit the citizen and the planning sector in particular as it is now proposed that the planning function be devolved to local government.

8.4 In 2010 the Ombudsman investigated a complaint about Coleraine Borough Council and their actions in respect of a tender and award of a contract for a Town centre Partnership scheme. The Ombudsman found maladministration but no injustice to the complainant. More recently in 2013 he found maladministration on the part of a health trust in relation to the financial assessment made by the trust of an unsuccessful tenderer. The complainant would have been successful but for the unfair application of a particular financial tool to assess liquidity. These complaints have demonstrated the need for a consistent approach across the public sector to procurement decisions. This issue was further highlighted to the Ombudsman at a meeting of DFP Committee in 2011, a member of the Committee highlighted the issue of the problems faced by small businesses when faced with challenging the decisions of major government departments and public bodies with whom they seek to engage in business contracts. The fact that the Committee intend to extend the NIPSO jurisdiction to procurement is to be welcomed. Currently small businesses fear that their prospects of securing future business may be

adversely affected if they complain about a public procurement decision compounded by the fact that a legal challenge against a procurement decision is inhibited by the cost of judicial review.

9. Conclusion

9.1 The themes explored in this paper are the opinions and views of the Ombudsman and his senior staff. It is open for the Committee to consider these and other views in making their decisions around the own initiative authority. To that extent this is a thought starter paper and the Ombudsman commends the paper to the Committee for its consideration and further discussion.

Consultation on an inquiry into the consideration of powers of the Public Services Ombudsman for Wales

Annexe A
Consultation Questions

1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

   The Town Council understands and respects the role of the PSOW. The Code of Conduct guidance available to town and community councils has been communicated to all Town Councillors who have also had the opportunity to attend training sessions on the Code as provided by One Voice Wales and the Vale of Glamorgan Council.

Own initiative investigations

2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on "own initiative" investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.

A. It is important that PSOW has the power to investigate in order to assess whether there is a serious matter requiring investigation. Arrangements would need to be in place to require the PSOW to liaise with other relevant bodies.

3. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

A. There would be issues relating to over lapping responsibilities and mechanisms would need to be in place to ensure that communication and co-ordination of activity was in place.

4. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

A. The Town Council does not have a view on the financial costs and benefits except to say that own initiative investigations could save time and money in the long term.

Oral Complaints

5. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.

A. Any barriers to communication should be removed and permitting complaints to be submitted electronically or orally would remove what may be existing barriers. However there would need to be guidance to prevent vexatious complaints being submitted.

6. What other type/form of submission should be acceptable (e.g. email, website form, text messages)

A. E-mail, website form and text messages should all be accepted as a legitimate means of complaint submission.

7. Do you have a view on the financial costs and benefits of this provision?
Complaints handling across public services

A. There could be additional costs involved in seeking additional information from complainants.

8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.

A. The Town Council would support a model complaints policy becoming mandatory for public service bodies in Wales subject to the policy being appropriate for the sector.

9. Do you have a view on the financial costs and benefits of this provision?

Ombudsman's jurisdiction

A. There is already a model in place that could be adapted for each sector.

10. What are your general views on the Ombudsman's current jurisdiction?

A. The Town Council considers that the PSOW jurisdiction is about right however where there are overlapping elements into private healthcare it seems wrong to restrict the extent of an investigation.

11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman"s jurisdiction in this way?

A. The Town Council would support the proposed extension of the PSOW role.

12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)

A. No view

13. Do you have a view on the financial costs and benefits of this provision? Links with the courts

A. No view

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (i.e. this would give complainants the opportunity to decide which route is most appropriate for them.)

A. The Town Council considers that it would be important to provide the complainant with the choice.

15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?

A. The Town Council has no strong views but accepts that it may be appropriate in certain cases.

16. Do you have a view on the financial costs and benefits of this provision?

A. No view

Other issues

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

A. No comments

18. Schedule 3 of the current 2005 Act, provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

A. Natural Resource Wales.

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

A. After 5 years

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

A. There could be an escalation in complaints received and some may be inappropriate. There may also be conflict with professional bodies own investigations.

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

A. No comments

22. Do you have any comments on the following issues:

- jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;

- recommendations and findings – should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;

- protecting the title – there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;

- code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils resolutions. Whilst a

local resolution procedures exists and has been adopted by 22 local authorities, variance exists in practice.

A. Jurisdiction – no comment
Recommendations and Findings – should be binding subject to appeal arrangements being in place.
Protecting the Title – The Town Council agrees that the PSOW should give approval to use of title by others.
Code of Conduct Complaints – The Town Council considers it important that the PSOW retains his current remit for the town and community council sector to ensure the Code of Conduct is adhered to, maintaining consistent standards to ensure that the sector establishes credibility with Welsh Government.

23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

A. No comment

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

A. No comment

Consultation submission - Public Service Ombudsman for Wales

The Council had no issue with the Public Services Ombudsman (Wales) Act 2005, but instead felt that the changes would add to its effectiveness.

The Council was in favour of 'Own Initiative investigations' by the Ombudsman to allow the Ombudsman to be proactive in investigating patterns and common themes. It would also be in a position to investigate themes that other organisations may find it difficult to initiate.

Own Initiative investigations may overlap with other organisations however it would need to work within legal constraints. The organisation with the legal power to take action should take precedence, with the Ombudsman deferring to the higher power if necessary. I.e. the courts.

It was agreed that effective investigations of issues should cover its costs by reducing litigation and insurance costs in other areas.

The Council felt that both oral and electronic means of complaint should be accepted in order to comply with the Equality Act, and to encourage ease of communication.

As electronic communication is very cost effective this should reduce both the financial and time costs.

The Council was uncomfortable with a model complaints policy which public bodies would be compelled to adopt as the authorities varied in size and complexity. A comprehensive policy that was suitable for a large local authority or Health Authority may not be suitable for small Community Councils. The Council instead felt that an adaptable policy would be more effective that could be tailored to the size and complexity of the organisation.

As standardisation is usually cost effective this should have cost savings however the savings could be lost if the policy is too complex and rigid.

The Council felt that the jurisdiction of the Ombudsman was effective but that it should include Private healthcare. The funding should be by levy on the private health care companies but should not create costs for the complainant.

It was felt that the statutory bar currently in place should be removed as this would provide a cost effective method of recourse in the first instance through the Ombudsman which may reduce the level of litigation currently undertaken.

The Ombudsman should be given the authority to refer to the Courts on a point of law.

The Council felt that if additional powers were awarded it was vital that a review be undertaken before/ during and after instigation with regular reviews thereafter to identify issues. There should be a method of addressing issues quickly throughout the process.

Further reviews should be diarised to identify issues in jurisdiction.

The Ombudsman's recommendations should be binding but with a right of appeal written into the procedure.

There was no necessity for other 'Ombudsman' to first obtain approval from the Public Services Ombudsman for Wales.

The Council was however keen that the Ombudsman continue to focus on local Town and Community Council resolutions.

Overall the Committee felt that any changes needed to be reviewed on a regular basis to ensure that issues were identified and corrected early in the process.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

SICRHAU GWELLIANT TRWY AROLYGU ANNIBYNNOL A GWRTHRYCHOL

11 March 2015

Response to the consultation on an inquiry into the consideration of powers of the Public Services Ombudsman for Wales.

Healthcare Inspectorate Wales (HIW) welcomes the opportunity to contribute evidence to the consideration of powers of the Public Services Ombudsman for Wales.

The role of HIW is set out at Annex 1.

1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

The current Act seems to be regarded as a broadly effective framework for the Public Services Ombudsman in carrying out his core role of investigating complaints from the public where they feel that public service providers have let them down and ensuring that public bodies learn from this..

Own initiative investigations

2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on 'own initiative' investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.
3. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?
4. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

There are already a number of bodies that undertake this type of review and it would be important to ensure that there is no overlap with the roles of inspectorates and regulators, the Auditor General for Wales, and Commissioners.

It would be helpful to see an articulation of where the PSOW would have liked to exercise such powers in previous years and has not been able to do so. A number of

the example reviews that the PSOW gives in his supplementary evidence from other countries could have been undertaken by other bodies in Wales and there exists an opportunity for the PSOW to raise such matters with others as part of existing collaborative arrangements in Wales. I am not aware that this has been done previously.

It is therefore difficult to comment on the proposed costs and potential benefits as it is not clear how the Ombudsman has arrived at the estimate of 1-2 own initiative investigations per year without understanding where he may have wished to investigate in previous years and why such investigations could not have appropriately been undertaken by other existing organisations.

Oral complaints

5. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.
6. What other type/form of submission should be acceptable (e.g. email, website form, text messages)
7. Do you have a view on the financial costs and benefits of this provision?

We would support this proposal. The PSOW points out that some people may find it difficult to express themselves adequately in writing and it would therefore assist with access to allow complaints to submitted in a variety of formats.

It will, however, be important that the Ombudsman does capture for the record the information in a written format and does confirm with the complainant that the record accurately reflects the issues that they wished to raise.

As before it is difficult to comment on the potential costs without an estimate of the volume of complaints that are likely to be submitted in alternative formats and the potential additional administrative effort required.

Complaints handling across public services

8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.
9. Do you have a view on the financial costs and benefits of this provision?

The submission from the PSOW highlights that take up of the model complaints policy has been patchy, but is improving. It also identifies recent changes to the social services statutory complaints procedure. Given the improving picture that has

been identified I am not clear what case the Ombudsman is making for the need for the establishment of a Complaints Standards Authority and for enforcement powers.

Since the potential additional activity and workload associated with this has not been quantified it is difficult to comment on costs and benefits.

Ombudsman's jurisdiction

10. What are your general views on the Ombudsman's current jurisdiction?
11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?
12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)
13. Do you have a view on the financial costs and benefits of this provision?

The Social Care and Well-being (Wales) Act 2014 extended the jurisdiction of the Ombudsman to include care homes, domiciliary care and palliative care. In general I support provisions that, where appropriate, bring the arrangements around health and social care into alignment and avoid arbitrary sectoral distinctions.

The Ombudsman's supplementary evidence is clear that he is specifically seeking powers to be able to look into care and treatment provided by a private health care provider where that care/ treatment has stemmed from the NHS, or has been a part of a person's health care pathway which has also involved the NHS. This appears reasonable.

I would anticipate that the Ombudsman's role would be to intervene where existing mechanisms have failed to reach a satisfactory conclusion. It would therefore be important to map how the existing complaints processes for NHS and private healthcare worked in relation to the Ombudsman in order to provide clear and simple guidance for complainants as to the route they should follow.

The potential costs of such an extended role would need to be monitored, but the Ombudsman is clear that he would expect cases of this type to be very small in number.

Links with the courts

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to

a court, tribunal or other mechanism for review? (ie this would give complainants the opportunity to decide which route is most appropriate for them.)

15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?
16. Do you have a view on the financial costs and benefits of this provision?

HIW does not have a view on this.

Other issues

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

HIW does not.

18. Schedule 3 of the current 2005 Act, provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

We are not aware of any other bodies or organisations that should be included at present.

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

Given the uncertainty surrounding the potential workload and costs associated with new powers these should be monitored annually and evaluated after a maximum of five years.

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

There is the potential for confusion and duplication around the role of the Ombudsman in relation to the role of other audit, inspection, regulatory bodies and in relation to Commissioners, particularly with regard to own initiative investigations.

There is the potential for public confusion around the route they should take to pursue complaints and seek redress should the Ombudsman's jurisdiction change. At present the Community Health Councils can provide advocacy and support for patients complaining about NHS care and it may be appropriate to consider a similar extension to the scope of support they can provide to patients receiving a combination of NHS and private health care.

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

For a number of these proposals the Ombudsman has not set out clearly the scale of the problems that he is trying to address. In the absence of this information we lack a robust basis on which to quantify the likely additional workload and the resources likely to be required to implement the proposed new powers.

22. Do you have any comments on the following issues:

- jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;

The bodies under the Ombudsman's jurisdiction should be subject to regular review

- recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;

It is difficult to comment without understanding on how many occasions, and on what basis, public bodies have previously rejected the findings.

- protecting the title - there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;

HIW does not have a view on this.

- code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils' resolutions. Whilst local resolution procedures exists and has been adopted by 22 local authorities, variance exists in practice.

HIW does not have a view on this.

23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

A broad range of proposed legislation and reform is likely to impact upon the environment in which the PSOW operates. The response to own initiative investigations highlights the landscape in which the PSOW operates and this

landscape continues to evolve. A key requirement is to be able to communicate clearly to the public the role of each organisation and their specific purpose. It is important that changes to the role of one body are not considered in isolation from the changes being proposed to others.

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

No.

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales.

Purpose

To provide the public with independent and objective assurance of the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements.

Values

- **Patient-centred:** we place patients, service users and public experience at the heart of what we do
- **Openness and honesty:** in the way we report and in all our dealings with stakeholders
- **Collaboration**: building effective partnerships internally and externally
- **Professionalism**: maintaining high standards of delivery and constantly seeking to improve
- **Proportionality:** ensuring efficiency, effectiveness and proportionality in our approach.

Outcomes

Provide assurance:

Provide independent assurance on the safety, quality and availability of healthcare by effective regulation and reporting openly and clearly on our inspections and investigations.

Promote improvement:

Encourage and support improvements in care through reporting and sharing good practice and areas where action is required.

Strengthen the voice of patients:

Place patient experience at the heart of our inspection and investigation processes.

Influence policy and standards:

Use our experience of service delivery to influence policy, standards and practice.

Marshfield Community Council

Serving the Communities of Castleton & Marshfield

Chairman: Mr Alan Chase
Clerk: Mr G C Thomas 4 Kenilworth Road Newport South Wales NP19 8JQ
Tel: 01633 664285
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Ms Jocelyn Davies AM
c/o Committee Clerk
Finance Committee
National Assembly for Wales
Cardiff Bay,
CF99 1NA.

13th March 2015

Dear Madam

Consultation on an inquiry into the consideration of powers of the Public Services Ombudsman for Wales

Marshfield Community Council has resolved to support the five proposed changes to strengthen the Public Services Ombudsman's role.

Yours sincerely
G C Thomas
Clerk to the Council

Marshfield Community Council

Serving the Communities of Castleton & Marshfield

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Response to the Consultation on an Inquiry into the Consideration of Powers of the Public Services Ombudsman for Wales,
conducted by the Finance Committee of the National Assembly for Wales,
from Brian Thompson, Liverpool Law School, the University of Liverpool.

Introduction

1. I welcome this initiative by the Finance Committee and am pleased to respond to the request to offer my views. My major area of research is in Administrative Justice and I was a member of the Administrative Justice and Tribunals Council, am a member of the Tribunal Procedure Committee and act as an adviser to the Northern Ireland Ombudsman. With my colleagues I conducted comparative research on the public services ombudsmen in the UK and Ireland, Australia and New Zealand (*The Ombudsman Enterprise and Administrative Justice*, T. Buck, R. Kirkham and B. Thompson, Ashgate, 2011). I draw on this and subsequent research in responding to the consultation questions.

2. Before getting into the specific questions raised in the consultation, I wish to make some introductory remarks about context.

3. The ombudsman institution is a pivotal figure in administrative justice because of the twin objectives of providing effective redress and seeking to improve services. Complaints are not the only way in which people can try to resolve their disputes about the delivery of public services. In some cases they will have the right to appeal a decision to an independent tribunal and they may have a possible remedy in going to court. The distinction between a complaint and an appeal is not well understood by the public, and there is further complexity arising out of the evolving devolution settlement with some public services devolved to Wales such as the NHS, and others reserved to Westminster and Whitehall such as social security. In addition some services are delivered by private not public bodies.

4. Those, including me, who advocate viewing administrative justice as a system, argue that the need to adopt a citizens' or user's perspective leads to a holistic approach which not only guides and supports people through the maze of the different institutions and mechanisms of redress for the different services, but also seeks to ensure that lessons are learned so that services can be improved with a view to getting things right first time.

5. There is a tension between fragmentation and integration. The Administrative Justice and Tribunals Council and its Scottish and Welsh Committees provided a way in which advice could be given to Ministers in London, Cardiff and Edinburgh about administrative justice within and across the national boundaries but this has been lost with the abolition of those bodies. The Committee on Administrative Justice and Tribunals Wales is a temporary non-statutory body which provides advice to Welsh Ministers This body has a limited remit and there is a need for collaboration between the different levels of governments in their delivery of services to ensure that people

can be advised, supported and guided through the redress labyrinth. Just as it is proposed that the Ombudsman be given jurisdiction over private health care, might also the remit in Complaints Wales be extended to cover not only devolved tribunals such as the Special Educational Needs Tribunal for Wales but also non-devolved tribunals such as social security?

Effectiveness of the Ombudsman

6. The 2005 statute provided a benchmark for some aspects of ombudsman practice reflected in its inclusion in a consultation on reform of the Northern Ireland Ombudsman by the Northern Ireland Assembly and the Law Commission's *Public Services Ombudsmen* report. As the Ombudsman's proposals suggest, there are points that could be improved, not least in changing the culture so that lessons are not simply identified and disseminated but also acted upon to get things right first time.

Own Initiative Investigations

7. One of the recommendations for reform of Ombudsmen in the UK which my colleagues and I made in our book was that the power of own initiative investigations should be granted. We were very struck by the view of the Australian ombudsmen who we interviewed, that they could not conceive of doing the job without this power.

8. I suggest that they are needed because not everyone who has suffered through poor service will complain about it, particularly those who are amongst the most vulnerable, the elderly, the young and those with physical and learning disabilities.

9. Australian experience of this power tends to show that in states with a comparable population to Wales, the power is exercised carefully with between 2 to 4 such investigations being conducted each year. They are carefully planned and they require significant resources, and so there are constraints upon them.

10. I would suggest that concerns about their use leading to 'mission drift' or 'fishing expeditions' or being an unwarranted intrusion upon public bodies are misplaced. The remit of the Ombudsman is dealing with injustice or hardship arising from maladministration or service failure. The Australian legislation does not require consultation but it would be a foolish Ombudsman who would not consult and co-ordinate with others. The closest analogous power which any UK officer has would be the power to conduct Value for Money Audits by the UK's Auditors-General.

11. Nonetheless it would be prudent to require consultation, particularly with the Wales Audit Office, as well as other interested parties. Criteria and guidance will have to be devised to manage the various stages of an own initiative investigation from the identification of topic and commissioning of the investigation, through to its conduct, publication of the report and subsequent review of the exercise and its outcomes.

Oral Complaints

12. I support the Law Commission's analysis and proposals simply to require the Ombudsman to publish guidance on how complaints should be made. This flexible approach allows for responding to developments in technology and for the development of norms and expectations. For example there are confidentiality and privacy issues which arise out of the use of social media but not with email or forms on websites.

Complaints Handling Across Public Services

13. It might have been hoped that the size of Wales' population and public services would have led to greater voluntary adoption of the Model Concerns and Complaints Policy. It therefore seems that legislative underpinning might be required and this could be part of a Welsh development of the role of the Complaints Standards Authority which was conferred on the Scottish Public Services Ombudsman. (I shall say more about this function later.) The sectoral approach followed in Scotland means that there is a common core for a complaints procedure which can be tuned to the particularities of different sectors, local councils, health, Welsh Government departments and bodies, housing. This makes it easier for public bodies, the public and their advisors alike to use the complaints procedure, and is likely to reduce the cost of training in, and publicity, advice and guidance about, the procedures.

Ombudsman's Jurisdiction

14. At the 2012 International Ombudsman Institute Conference in Wellington, Peter Tyndall the previous Ombudsman and I gave papers in which we differed on whether public services ombudsmen should retain jurisdiction if a service is privatised. I am content for a Public Services Ombudsman to relinquish jurisdiction so long as the arrangements for dealing with complaints meet certain criteria:
    - Putting It Right (on complaint handling and remedies);
    - Getting It Right (on offering guidance and feedback) and
    - Setting It Right (the accountability and independence arrangements).

15. These criteria are met by the UK's Public Services Ombudsmen and by most of the Private Ombudsman schemes. I think that the EU Directive on Alternative Dispute Resolution for Consumer Disputes (2013/11/EU) would meet those criteria but we have to see how the UK will implement its responsibilities under the directive and the arrangements which the various sectors of consumer services establish.

16. In relation to whether or not private health care should be brought within the Ombudsman's jurisdiction, as he requests, there are various factors to consider. One is that private social and palliative care have been brought within jurisdiction and given the policy which seeks to integrate health and social care, it might be thought sensible that a review stage in both health and social complaint processes be carried out by the same body. While some complaints will be about one type of care, there will be some in which both types of care are the subject of complaint. If combined complaints outnumber single complaints which escalate to a review stage, then the case for a common review stage body is strengthened.

17. If jurisdiction is extended then the private health care sector will have to bear the cost of handling private health care cases by the ombudsman and there are various models in private ombudsman schemes which can be considered.

18. I would suggest that careful thought be given when extending the jurisdiction of a Public Services Ombudsman to the private sector. It can be justified for principled and pragmatic reasons but perhaps there is a greater burden of proof when it is an extension rather than seeking to retain arrangements upon the privatisation of a public service. Concern has been expressed about the possibility of a power of own initiative investigation leading to mission drift, but I would suggest that it is more likely that it will be government and legislatures that contribute to mission drift by extending a public services ombudsman's jurisdiction.

Links With The Courts

19. It is very unfortunate that there has not yet been a full response to the Law Commission's 2011 report *Public Services Ombudsmen*. The Ministry of Justice is required to respond to Law Commission reports no later than 12 months after publication. The Cabinet Office takes the lead on ombudsman policy and it seems that work which the Minister for Government Policy and the Chancellor of the Duchy of Lancaster, the Rt. Hon. Oliver Letwin MP is overseeing, may soon be published. We do not know the extent to which this will deal with UK wide aspects of ombudsmen and aspects relating to England and Wales and just England. It is likely to address the issue of unifying the public ombudsman service in England and thus catching up with Wales and Scotland. This would have implications for the Parliamentary Ombudsman whose complicated jurisdiction covers England; England and Wales; England, Wales and Scotland; and England, Wales, Scotland and Northern Ireland.

20. The trouble is that the set of recommendations which the Law Commission made on the links with courts apply to England and Wales and therefore involve the Ministry of Justice as well as the judges responsible for the Administrative Court and the Civil Procedure Rules.

21. Bearing in mind that the Finance Committee is considering reforms which can be legislated for in the life of the current National Assembly for Wales, I would suggest that there is only one of the Law Commission's proposals on links with the courts for which the Assembly has legislative competence and this is the statutory bar. This is the provision which stipulates that if there is another remedy available to a complainant then the Ombudsman should not accept the case unless, in the exercise of discretion, it is thought that it would not be reasonable to expect the complainant to have, or have had, recourse to that alternative.

22. The Law Commission proposed modifying this, so the position would be that even if a complainant had an alternative remedy, it would be within the ombudsman's jurisdiction, but the case could be declined on the basis of the ombudsman's view that there was a better alternative for the complainant.

23. I would support this proposal as it should make things slightly easier for complainants if the default position is within jurisdiction unless the ombudsman declines. It would need to be accompanied by information produced by the ombudsman giving examples of cases in which there might be a better alternative remedy.

Other Matters

24. I wish to address the following points; Enhancing the Learning of Lessons to Improve Service; Ombudsman as a Complaints Standards Authority; Findings and Recommendations; and Protecting the Ombudsman Name.

25. While ombudsman identify and disseminate proposals for improving service, we do not have much evidence to show if this is effective. The proposal to confer an own initiative power of investigation should lead to more lessons being learned but will they be implemented? It is suggested that what is required is cultural change which will require various actions taken by various bodies. Agencies with audit, regulatory and inspection functions could incorporate into their work consideration of complaints *and* review of action taken by bodies in response to complaints. An approach which simply calls for a body to report annually on the number of complaints made to the ombudsman about it and the number of those upheld, is useful information but what is needed is 'narratives as well as numbers'. If the body gives details about the complaints and remedial action, this enables it and auditors, regulators and inspectors' elected representatives and the public to review the effectiveness of the response.

26. I think the necessary cultural change can be promoted by the Scottish Complaint Standards Authority role. As I understand it, the Scottish Public Services Ombudsman having worked with the public service sectors to produce the model complaints processes, then expects those sectors to take ownership and to review the processes and their outcomes and to share best practice. Best complaints handling practice includes actively seeking out and using insight from complaints and comments to improve service. If bodies welcome complaints as a gift, they will make it easier to complain, and will provide effective redress and make it more likely that lessons will be learned and service consequently improved. This can be reinforced by oversight bodies if they have the 'narratives as well as numbers'.

27. Public bodies have various requirements imposed upon them and they may feel that adding to them will impede rather than assist them in doing their job. The most successful bodies know that handling complaints well not only fulfils the end of fixing problems but of enabling them to carry out their tasks effectively.

28. It would be helpful if there was collaboration and co-ordination between the UK central government and the devolved institutions over the Law Commission's proposal to make ombudsmen findings of injustice caused by maladministration or hardship caused by service failure binding. The ombudsmen's suggested remedies would remain recommendations. My initial reaction was not to support this proposal but my opposition is waning. I think it desirable that the position should be the same for the Parliamentary Ombudsman and the Public Services Ombudsmen in the rest of the UK. It had been thought in England the Local Government Ombudsmen's

findings were not binding until a Court of Appeal decision. This distinction having resulted from judicial interpretation of legislation it is desirable that clear legislation standardises the position. While I think there is scope for innovation in the UK's different jurisdictions, there are some things which should be common and in addition to findings this should also include deciding if the UK should follow New Zealand.in requiring that permission be required to use the term ombudsman and to make it a criminal offence to use the term ombudsman without such permission.

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19 March 2015

The Local Democracy and Boundary Commission for Wales (the Commission) welcomes the opportunity to contribute to the Finance Committee' s inquiry into the consideration of powers of the Public Services Ombudsman for Wales.

The Commission considered the proposals and the Ombudsman paper that provided background information and details of the proposals. The Commission decided that there was only one proposal that it wished to comment on and that was in respect of the proposal to accept oral complaints.

Whilst the Commission considers it appropriate to expand the category of written evidence to include e-mails and online forms, we are of the view that there are difficulties when it comes to oral evidence. We consider that in order to ensure oral evidence accurately reflects the views of the complainant their needs to be some form of transcription or recording of the conversation. This will require additional resources. A complaint made orally by telephone or face to face may lack structure and accuracy and may lead to a misunderstanding of the nature of the complaint. In order to mitigate against this risk it will always require the additional step of setting the complaint out in writing and going back to the complainant to read this out for them to agree it. We consider that for those wishing to make a complaint who are not confident in making it in writing there is assistance available for them in the wider community.

Yours faithfully

Steve Halsall
Chief Executive

Appendix A

Consultation on an inquiry into the consideration of powers of the Public Services Ombudsman for Wales - Response from Wrexham County Borough Council.

This response is a supplementary response to that of the WLGA, which Wrexham County Borough Council has contributed to and fully supports.

Consultation Questions

1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

Own initiative investigations

2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on 'own initiative' investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.

Wrexham County Borough Council (WCBC) remains unclear as to what action or incident could cause the Ombudsman to begin an investigation if this were not prompted by a complaint.

We believe that if this were to be implemented, the Ombudsman should have strict timescales to adhere to, as Local Authorities have in managing complaints. This would reduce the work pressures on the relevant departments and provide clarity for all parties on the length of the process.

3. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

WCBC shares the concerns of the WLGA and Welsh Government regarding the potential duplication of inspections by other bodies.

There is also a potential for misuse by those who may wish to particular actions of the council to be scrutinised for their own agenda and therefore use the Ombudsman to do this.

Would the Ombudsman still be viewed as an impartial body for complaints by the public if it was regularly involved with non-complaint investigations with Local Authorities?

4. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

The primary concerns would be for the resources required to support the Ombudsman in undertaking any investigation. As stated above, the timescales and procedures for any investigation would need to be clearly defined to ensure the Council can comply with this and support any staff that may be central to the investigation.

Oral Complaints

5. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.

WCBC accepts complaints made in any form the customer wishes to. This ensures we do not discriminate against those who do not have the capacity to put things in writing. However, where this is the case, we ensure that the method we have used for recording the complaint is agreed by the complainant (e.g. if complaint made verbally, the notes would be written up by an officer and the accuracy of these notes confirmed by the complainant.)

6. What other type/form of submission should be acceptable (e.g. email, website form, text messages)

As above

7. Do you have a view on the financial costs and benefits of this provision?

There is no additional cost to meeting a complainant other than officer time. However the council would not refuse a meeting where there is merit.

Complaints handling across public services

8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.

WCBC have already adopted the model complaints policy as have 21 of the 22 Local Authorities at the time of reporting. We believe this model has led to an improvement in the management of complaints. This is supported by a recent invitation to WCBC from the Ombudsman to give a presentation having been recognised as a Local Authority who manage complaints well.

9. Do you have a view on the financial costs and benefits of this provision?

n/a

Ombudsman's jurisdiction

10. What are your general views on the Ombudsman's current jurisdiction?

WCBC have no concerns regarding the current jurisdiction of the Ombudsman.

11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public

healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?

n/a

12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)

n/a

13. Do you have a view on the financial costs and benefits of this provision?

n/a

Links with the courts

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (ie this would give complainants the opportunity to decide which route is most appropriate for them.)

WCBC fully supports the response of the WLGA in that the current jurisdiction is appropriate.

15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?

As above

16. Do you have a view on the financial costs and benefits of this provision?

As above

Other issues

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

No

18. Schedule 3 **of the current 2005 Act, provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?**

WCBC considers the list appropriate.

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

WCBC supports the position stated within the WLGA response.

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

As above

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

As above

22. Do you have any comments on the following issues:

- **jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;**
- **recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;**
- **protecting the title - there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;**
- **code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils' resolutions. Whilst a local resolution procedures exists and has been adopted by 22 local authorities, variance exists in practice.**

WCBC believe the Ombudsman's powers in investigating complaints regarding councillor conduct to be both appropriate and beneficial. In independently investigating the complaint, it ensures that no Council officer is put in a compromising position.

23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

WCBC supports the position stated within the WLGA response.

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

No

	National Assembly for Wales Finance Committee
Purpose:	The Welsh NHS Confederation's response to the inquiry into the consideration of powers of the Public Services Ombudsman for Wales
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Officer, Welsh NHS Confederation Nesta.lloyd-jones@welshconfed.org Tel: 02920 349857
Date created:	19 March 2015

Introduction

1. The Welsh NHS Confederation, on behalf of its members, welcomes the opportunity to respond to the Finance Committee's inquiry into the consideration of powers of the Public Services Ombudsman for Wales (PSOW).

2. By representing the seven Health Boards and three NHS Trusts in Wales, the Welsh NHS Confederation brings together the full range of organisations that make up the modern NHS in Wales. Our aim is to reflect the different perspectives as well as the common views of the organisations we represent.

3. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work. Members' involvement underpins all our various activities and we are pleased to have all Local Health Boards and NHS Trusts in Wales as our members.

4. The Welsh NHS Confederation and its members are committed to working with the Welsh Government and its partners to ensure there is a strong NHS which delivers high quality services to the people of Wales.

Summary

5. Patients' expectations of the NHS are growing. It is not only about whether their treatment worked or how long they had to wait, but how they were cared for by staff, how they were spoken to and how comfortable they were made to feel. Quality of care in all its forms is a critical issue for healthcare providers and something that the NHS must get right.

6. Patients in Wales come into contact with the NHS more than 22 million times each year. A recent survey showed that 94% of patients were satisfied with the overall care they received and 97% of patients in Wales say they were treated with dignity and respect when using hospital services.[i] However, as Keith Evans' review[ii] into NHS complaints recently highlighted, there is always room for improvement and there is no doubt that there are areas where more can be done. Local Health Boards (LHBs) and NHS Trusts are doing more and more to encourage feedback from patients, their families and their carers to make sure they are getting these things right, and treating patients and their families in the way they should expect; with dignity, compassion and respect.

7. Effective investigative processes and feedback and complaints systems are an integral part of an open and transparent culture in the NHS. The complaints process within the NHS has become more accessible and complaints should be, and generally are, seen by the NHS in Wales as an opportunity to improve services. The PSOW is a key part of this, and provides an effective

escalating route for complaints. It is independent of the service which is important to ensure public confidence in the NHS.

Consultation Questions

Q1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

8. The PSOW provides an effective escalation route for complainants and is the final tier in the complaints system in Wales. The PSOW is independent of the services in their jurisdiction and uses an investigative rather than adversarial approach. It is free to use and is an objective arbiter of complaints. It has a dual role - investigating complaints and improving services – and therefore provides a fair and unbiased arena for complainants.

9. Presently there are some limitations with the current powers within the Public Services Ombudsman (Wales) Act 2005. The current powers prevent some of the population from making a complaint, or for the PSOW to operate in the most effective manner, for example in relation to private care. The Act needs to be updated to reflect modern society and the nature of modern public services in Wales.

10. It is difficult to evidence clearly the effectiveness of the PSOW. The objectives of the PSOW are to ensure an absence of maladministration during the complaints process and in decision making. The focus of the office is therefore upon process not outcome. The result may be dissatisfied stakeholders who may be subject to fair process however may not think the outcome is fair and cannot appeal the findings. In addition, it is unclear how the PSOW evaluates its performance and effectiveness - would a reduction in individual complaints be a sign of success? We recommend that the PSOW should consider appropriate measures of success and not just rely on monitoring numbers and analysis of cases from each NHS body / public service organisation.

Own initiative investigations

Q2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on "own initiative" investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.

11. The Welsh NHS Confederation recommends that the PSOW should be able to undertake "own initiative" investigations where there is **firm evidence** of widespread maladministration or service failure affecting the population. In addition other organisations, such as Healthcare Inspectorate Wales (HIW), have the authority to undertake own initiative investigations.

12. While the PSOW is ideally placed to pick up issues both within organisations and across Wales and bring an independent view to the concerns, the NHS in Wales would be concerned about the introduction of "own initiative" investigations by the PSOW, unless there is **firm evidence**, as this would be a significant retraction from their prime purpose and remit as a complaints arbitrator. In addition, given the existing roles of the regulatory bodies whose activities impact upon the activities of the NHS bodies in Wales, we feel that the addition of such "own initiative" investigations by the PSOW would represent a duplication of activities between such bodies. It will be essential that this does not lead to repetitive inspection and investigation where there are already inspection or regulatory bodies in place, for example HIW. Careful consideration of the role of other regulators/ inspectorate bodies, such as HIW and Community Health Councils, are required and there will need to be explicit pathways in place to ensure that where relevant

intelligence is passed to an alternative body for investigation the PSOW is made aware of this, and vice versa.

13. In addition, while "own initiative" investigation powers may seem an appropriate addition, there are potential implications for the NHS in Wales. The PSOW could choose to investigate a specific issue where there are no specific themes for the PSOW to investigate, for example the proposed changes could allow the PSOW to investigate the failings of the Welsh Ambulance Service NHS Trust to meet the ambulance response times in a specific area or service redesign in another area. PSOW currently imposes financial penalties in regards to maladministration which are subjective - would service failings also result in penalties? There is a risk that the PSOW could end up with an agenda that is not in the best interests of the public.

14. Finally, in order to fully respond to this question there needs to be further explanation of this power. We note that in the Republic of Ireland only 5 such reviews were undertaken between 2001 and 2010. Clarification is required as to the triggers for these powers to be used. Furthermore there is need for careful consideration of the role of other regulatory/ inspectorate bodies such as HIW and Community Health Councils and the need for sharing of intelligence to ensure that the most appropriate body undertakes the review.

Q3. Do you have any concerns that own - initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

15. As highlighted previously, there is a significant risk of PSOW responsibilities overlapping with the responsibilities of other bodies. NHS bodies across Wales are accountable to the Welsh Government's Healthcare Quality Division in relation to service failing and subsequent Serious Adverse Incidents investigations. There may also be overlapping in regards to the responsibility and purpose of HIW. HIW provides assurances on the quality, safety and effectiveness of healthcare services and they also make recommendations to healthcare organisations to promote improvements.

16. The Welsh NHS Confederation believes it would be more appropriate that where the PSOW identifies generic issues which require investigation, following the provision of clear evidence and a rationale to why there should be such an investigation, he/ she should link into the existing bodies who are resourced and experienced in undertaking such investigations. This approach would avoid duplication of activities, prevent placing unreasonable burdens on NHS bodies, and improve the utilisation of limited resources. It would ensure that any investigation being undertaken would reflect and consider the intelligence and main issues of the relevant NHS body.

17. The Welsh NHS Confederation recommends if any "own initiative" investigations were being considered, there would need to be an early dialogue between the PSOW office, the NHS service and Welsh Government/HIW and other investigative bodies.

Q4. Do you have a view on the likely financial costs and benefits of the Ombudsman having "own-initiative" powers?

18. The costs and benefits are difficult to quantify without full understanding of the powers sought. The scale and scope of "own initiative" investigations have the potential to be far more comprehensive than those currently undertaken through the 2005 Act. This therefore has the

potential for such investigations to be lengthy and costly. Factors that might introduce costs could include:

a) PSOW's staffing: There will be a cost implication in regard to staffing depending on how many investigations PSOW would undertake each year. It could require additional PSOW staff to accommodate the additional investigations.
b) Cost to the NHS in Wales: There would also be a financial cost to the NHS in Wales in relation to the additional time spent on undertaking investigations. The NHS in Wales is currently obliged to support timely investigations and these additional powers could increase the amount of information that will be asked of NHS bodies.

19. While there are financial implications the benefits might include earlier recognition of pan-Wales issues which could help reduce claims. However the NHS in Wales does already have clear bodies in place to audit and consider system-wide issues.

20. The Welsh NHS Confederation recommends that a cost-benefit analysis will need to be undertaken as part of the decision making process. Given the work of the existing bodies in this area it is likely that the cost benefits would be disproportionate.

Oral Complaints

Q5. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.

21. The Welsh NHS Confederation recommends that the PSOW should accept complaints in whichever format best suits the complainant, including through the medium of Welsh. It is very important that the investigative powers of the PSOW are accessible to all.

22. Only accepting complaints in writing may inhibit or prevent some members of the public from pursuing a complaint. The average reading age in the UK is that of an educated nine-year-old and the legacy of illiteracy and the ability to write is more widespread than previously believed. The opportunity to receive complaints by word of mouth will ensure that those members of the public who are unable to communicate effectively in writing will be considered. It would also be useful that consideration is given to advocacy support/ individuals are assisted in formulating their concerns.

23. However, there will need to be robust mechanisms to ensure that what the receiver of the complaint (PSOW staff) has recorded and what the complainant wants to say are the same. There will need to be clear guidance on the verification of the information and it may be necessary for PSOW staff to meet the complainant and agree the details of the complaint.

24. The NHS in Wales is working under Putting Things Right[iii] Regulations and is required to provide a response to oral complaints within 48 hours. It is unclear whether those principles will be applied to oral concerns taken by PSOW. If so this will place an immense amount of pressure in the system to accommodate a response.

25. Furthermore, we would need to consider the amount of information PSOW would be willing to accept as an oral concern before they would instigate an investigation. This could potentially increase the number of vexatious complaints received because of the ease of access and this would need to be monitored closely.

Q6. What other type/form of submission should be acceptable (e.g. email, website form, text messages)

26. To continue from the response to question 5, submissions should be acceptable in all formats to ensure it is as inclusive as possible for the population. This would include: text, email, web submission, letter, and orally either in person or over the telephone. There will need to be firm checks and balances in place across all of these formats so that the PSOW can be assured they have captured exactly what the complainant is requiring and to prevent misinterpretation. This approach is also congruent with the NHS Wales Putting Things Right procedures.

27. However, it is not just about the types of access that are acceptable as all NHS bodies in Wales use a variety of access routes highlighted above. The question should be around the type and level of information that would be required prior to starting an investigation. This should be clarified as there is a risk that work could be commenced on very little information or evidence.

Q7. Do you have a view on the financial costs and benefits of this provision?

28. Again it is difficult to quantify without further information. This will incur additional costs to implement initially, for example setting up relevant systems and processes to enable this to happen, additional staffing costs as the complaints will be taken orally and ensuring the complaints have been recorded correctly will take additional time. As this will also enable more people to raise complaints more easily to the PSOW it will almost certainly result in more complaints being raised, which will increase costs to both the PSOW office and the body being investigated. However, as highlighted, the benefits are that all members of the public with difficulties in writing or communicating will have the same opportunity as others to raise concerns.

Complaints handling across public services

Q8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh Government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt? Please explain your answer.

29. The Welsh NHS Confederation does not believe that there should be a model complaints policy which all public bodies should work to because there are a number of strategies and policies with which different public bodies have to comply. The Ombudsman has a clear remit in supporting public sector complaints handling. How this would be executed requires further examination.

30. Any mandated model complaints policy would need to fully meet the legislative requirements placed on public sector organisations, for example National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. There has been a significant amount of work undertaken following the implementation of the Putting Things Right Regulations. Following this in 2014 the Minister for Health and Social Services asked for an independent review of complaint handling in Wales (the Keith Evans review). There were 109 recommendations and the National Quality and Safety Forum has already started to ensure an all-Wales approach has been established to achieve this. A number of work streams have begun and one is to review the Putting Things Right guidance which may influence our complaint policies so there is potential for duplication of work.

31. One of the main findings of the Keith Evans review was a lack of consistency, therefore the interpretation of an imposed complaints policy would become individual and subjective. Each health body adheres to the principles of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
32. The role of PSOW is to ensure consistency in relation to process and administration and this responsibility is essential to ensure fairness and consistency. Given that the Welsh Government was the author of the Putting Things Right regulations and is currently leading on the current review, it would be appropriate for the body which owns the policy to define the policy. It is arguable that to empower the PSOW to develop policy could create a conflict in its subsequent role as an independent arbitrator and would suggest that this could detract from its current position.

33. It is also important to note an area of inconsistency and confusion with regard to redress. Putting Things Right clearly and succinctly defines redress. Given that the PSOW uses the same terminology in respect of its outcome - albeit defined significantly differently - this causes real problems in practice when dealing with patients and families. It is suggested that action should be taken to avoid any confusion between how PSOW interprets redress from that of other health bodies in Wales.[iv]

34. Further, it is felt that given the ongoing work streams of Putting Things Right, being led by the Welsh Government following the findings of the Keith Evans review, it is the wrong time to enforce a new policy. The role of the PSOW is vitally important as an independent arbitrator and as a consequence it would be more prudent for PSOW to focus on making recommendations when it identifies poor working practices and poor processes as part of its individual investigations and make suggestions how the complaints process could be improved. This would lead to improved consistency across Wales.

Q9. Do you have a view on the financial costs and benefits of this provision?

35. The model complaints policy across public sector bodies would have major benefits for the complainant and it would make multi-agency working easier. However, if the NHS in Wales were to adopt a complaints policy there would be a financial cost to change its policies in relation to Putting Things Right. There are clear disadvantages in relation to the potential conflicting view from the Keith Evans review, the principles outlined in Putting Things Right and the changes that would come from a complaint model being imposed by the PSOW.

Ombudsman's jurisdiction

Q10. What are your general views on the Ombudsman's current jurisdiction?

36. Overall the Welsh NHS Confederation believes that the current jurisdiction of the PSOW is appropriate and sufficiently extensive. Its role, as that of an independent arbitrator, cannot be understated and should not be compromised by the extension of its role. The focus on learning and service improvement by PSOW is commendable; however there is a lack of clear process in place for a cyclical approach to review and monitor the impact of its service improvement recommendations.

37. Within Wales there is clear access to free legal aid - both in appropriate cases through the existing legal system and also under Putting Things Right - which are clearly detailed under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. There is a risk there would be duplicity if the current jurisdiction of the Ombudsman was extended.

The access routes available to the public could become blurred and difficult to navigate because of multiple avenues available and as a consequence there would be potential for variation and waste in relation to the work of the courts.

Q 11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?

38. The Welsh NHS Confederation would agree with extending the PSOW's jurisdiction in this way. It would be beneficial if the PSOW is able to reflect the population's whole journey across public services, which may include private healthcare. Without this, the effectiveness of some public service investigations may be limited because the PSOW's inability to investigate private care as part of an NHS patient's journey/ pathway does mean that the PSOW cannot give the complainant a full response and this could be deemed unsatisfactory. Private care provision should be investigated with the same rigor and to the same standards as NHS services as patients could suffer the same detriment and the same degree of maladministration as within the NHS.

39. However, further clarity is required, for example would a private care provider be in accordance with the advice offered in an expert report? What would the sanctions be for failing to comply with a report and its recommendations and how would these be enforced?

Q 12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)

40. The private healthcare industry would need to consider this with PSOW. The same principles and approach should be adopted for both private and NHS healthcare investigations. Any findings in regard to maladministration or service failings should have the same principles applied as NHS health care to ensure consistency.

Q 13. Do you have a view on the financial costs and benefits of this provision?

41. Depending on how many private healthcare investigations PSOW would undertake it would require additional PSOW staff and this will have a cost implication. This is likely to cost the service more but would benefit both the complainant and the service in terms of lessons to learn. A clear funding formula will be required so this does not impact on the public finances and there will need to be a comprehensive plan agreed with private healthcare providers.

Links with the courts

Q 14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review (i.e. this would give complainants the opportunity to decide which route is most appropriate for them)?

42. This recommendation causes the Welsh NHS Confederation some concern due to the nature and details of the legal tests to be applied. This recommendation could create a dual tier of redress which, unless the existing identical legal tests were applied, could create inequity of approach

between the systems. This was a point which was considered during the development of the Putting Things Right redress process. It is important that equity and consistency is maintained.

43. In addition, there is a risk that the PSOW will become an arbitrator of the legal tests and be in direct conflict with the courts, and more importantly in an area where there is a lack of specialised legal skills and knowledge. As a minimum, there would need to be clear guidance on when PSOW could intervene and also in terms of which cases. There would seem to be potential impact on a range of legislation which would all need careful consideration.

44. The current system using the Putting Things Right redress provides access for patients and families to free legal advice while maintaining the defined tests which ensures equality. The process has inbuilt 'appeal' mechanisms in that patients and families receive quality free legal advice from clinical negligence specialist solicitors in relation to the accepted common legal test applied in such cases. This covers whether the subject matter of the concern is actually legal qualifying liability in tort, and the appropriateness of the settlement of the valuation of damages.

45. This is an existing process which is embedded into NHS bodies' culture and there is evidence in many cases that this works effectively for the benefit of both the patient and the health body. While there is a currently a cap on this of £25,000, this may be ultimately increased dependent upon the outcome of the review being undertaken in England. It is important that such a cap does apply between the legal complexities associated with higher value claims which require input from specialist lawyers.

Q 15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?

46. The court and legal costs for such a referral will need to be determined. Where the point directly relates to the current arbitration role of the PSOW, this would be understandable, however, in all other cases, this may not be appropriate and such actions should be taken by parties with a direct interest in the subject matter of the issues.

47. Also it would need to be identified as to who funds any legal requests. There should also be consideration of the role of legal advice to clarify a point of law rather than proceeding directly to the courts.

Q 16. Do you have a view on the financial costs and benefits of this provision?

48. As highlighted previously this could be significant as it envisages the creation of a dual system with the potential for inbuilt inequity. It would be extremely expensive for the PSOW to equip itself with the necessary skills and qualified staff to undertake such a role without creating inequity as indicated above.

49. Given the current systems and processes, it is suggested that emphasis should be placed on the development of these current systems rather than the development of a system that duplicates what has already been established. If there are any financial costs, these should be borne by the PSOW not the NHS/public sector.

Other issues

Q 17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

50. We have no specific examples to provide but there have been some examples where the PSOW determinations and reports have adversely affected the course of litigation in previous cases.

Q 18. Schedule 3 of the current 2005 Act, provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

51. As highlighted previously, it would be useful for private healthcare providers to be included within the PSOW's jurisdiction to investigate complaints. The PSOW last year investigated nearly 2,000 complaints, therefore a concern would be that with the inclusion of additional authorities how will PSOW predict the amount of cases they would be investigating? With the suggestion of oral complaints this could result in a significant increase in work volume that has not been considered or mapped at this present time.

Q 19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

52. If the extended powers were given, the impact should be evaluated on an annual basis and reported through the annual reporting process.

Q 20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

53. There are some unintended consequences that could arise as a result of these provisions becoming legislation. For example:
    a) There would be dual processes in place and there could be a misinterpretation of legal tests which could prejudice the NHS in Wales. This dual process would then lead to inequality across Wales as indicated in the detail above;
    b) There is a potential that a small number of the population will use "own initiative" investigations as a form of a 'public inquiry';
    c) There is the potential for some of the population to have repeated enquiries at a cost to public purse if the statutory bar is lifted;
    d) It could lead to confusion between the PSOW's powers and other regulators. Clarity on this would need to be established prior to it becoming legislation; and
    e) Increased demand upon the Health Boards to review the increased number of concerns without any additional resource. The Keith Evans review was clear in its recommendations that concerns teams within the NHS need to have the necessary resources in terms of appropriate staffing levels. While it is proposed that the PSOW office would have additional resource of £270,000 per annum, these proposed changes will have an effect upon NHS concerns teams and this should also be considered and resourced appropriately.

Q 21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

54. The clear outcomes for the public need to be measured in line with the costs. Additional outcomes would be tangible changes made to services / parts of services as a result of this legislation. It is important that the focus is not only on process measures.

55. As part of the cost-benefit analysis the level of fine by the PSOW must be considered, the number of cases taken on by the PSOW, which may increase due to additional route of submission, the number of second responses to the PSOW and complainants satisfaction with the outcome.

Q 22. Do you have any comments on the following issues:

- **jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;**

56. As highlighted previously private providers and companies as well as individuals, should be included.

- **Recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;**

57. Overall the Welsh NHS Confederation believes that the recommendations of the PSOW should not be binding. There should be an opportunity for a dialogue between the PSOW and Health Board to agree the findings. There have been a small number of occasions when the recommendations arising from an investigation have either been un-implementable or the conclusions from which they have been drawn have been incorrect. Thus far the particular Health Board has been able to negotiate accordingly with the Ombudsman in respect of these.

- **Protecting the title – there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;**

58. Approval should be gained but we do not believe it can come from the PSOW as there are other regulatory Ombudsman services, for example the Financial Service Ombudsman.

- **Code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils' resolutions. Whilst a local resolution procedures exists and has been adopted by 22 local authorities, variance exists in practice.**

59. We agree that the PSOW should focus on the elements of his work that deal with service users and service delivery but the PSOW must also engage with the Local Authority and town and community councils.

Q 23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

60. The Act should be as future proofed as much as possible to fully take proposed public sector reforms into consideration.

61. In relation to Local Government reforms, the Welsh NHS Confederation, on behalf of its members, has engaged significantly with the proposed changes. We welcomed the publication of the Williams Commission report and we responded to its recommendations, highlighting that we

recognised that they have the potential to support better integration and reduce overall demands on health, and drive improvements across the board. However, to date, Local Government re-organisation has dominated the debate surrounding the White Paper and the Commission's findings. Although the debate is a key part of refocusing public services in Wales we are concerned that this remains the focus. The potential reduction in the numbers of Local Authorities should aid multi-agency working. Working with fewer Local Authorities will streamline the integration process for Health Boards, and there will be fewer structural barriers to collaborative working across the board.

Q 24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

62. There should be a comprehensive impact assessment carried out on the proposed changes. It is reported that the workload of the PSOW increased by 11% last year.[v] The proposed changes will potentially increase its workload exponentially and it would be prudent to ask how the PSOW office intends to manage this unpredicted demand.

63. One of the main challenges for the NHS in Wales is the lack of learning from events. Following conclusion of their investigation PSOW should focus on learning. There should be a system of accountability and a review following the acceptance of PSOW recommendations. PSOW could hold a library of learning that could be used by other health bodies experiencing the same challenges. If an evaluation of a health body is undertaken following implementation of the recommendations and there is no evidence of learning or change then an escalation route could be introduced to HIW for further monitoring and consideration. Furthermore it may be more appropriate for the PSOW office to sit within a framework and a wider system within Wales and work with the existing regulators.

[i] Welsh Government, June 2014. Fundamentals of Care audit.
[ii] Keith Evans, June 2014. Review of concerns (complaints) handling within NHS Wales – 'Using the gift of complaints'.
[iii] Welsh Government, January 2014. Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011.
[iv] Welsh Government, January 2014. Section 7 Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011.
[v] Public Services Ombudsman for Wales, Annual Reports 2013 – 2014. http://www.ombudsman-wales.org.uk/en/publications.aspx

Written Response to the Finance Committee Inquiry into the Consideration of Powers of the Public Services Ombudsman

1. Care Forum Wales is grateful to the Finance Committee of the National Assembly for Wales for the opportunity to comment on the proposed amendments to the Public Services Ombudsman (Wales) Act 2005. Care Forum Wales is the main professional representative group for independent health and social care providers in Wales. Our 450 members provide services to all age groups, from looked after children to older people and cover all settings, including domiciliary care, supported living, residential care homes and hospices.

2. Care Forum Wales works in a public service ethos. We see our members as providing a public service, particularly since the majority of care services provided by our members are funded by statutory partners in the Local Authorities (social care) and NHS (health care). We are firmly committed to providing inclusive, citizen centred services that provide equally high quality outcomes whether self-funded or publicly funded. Our members do not, at present, tend to include private hospitals.

3. Power to Initiate Own Investigations

We can see the logic in the Ombudsman having the power to own initiate investigations, but paragraph 2.1 (d) is a very important proviso and we would expect the majority of cases to be referred to the regulators or commissioners. The care sector is the most heavily regulated and inspected of sectors and we would not want to see more inconsistency or duplication introduced. Any additional scrutiny would need to demonstrate additional value.

4. Oral Complaints

There is a strong argument for extending the use of oral complaints to make the system more inclusive. However, we would like to see more detailed planning of how this would be implemented in practice. Independent providers are in a relatively vulnerable position to complaints and whistle blowing and our experience has shown how important it is to capture and record oral complaints accurately. For example, some local safeguarding boards accept oral complaints without being backed up in writing and on occasion this has led to providers being asked to investigate alleged incidents of abuse or neglect on the basis of incomplete or inaccurate information. We would want to see a mechanism in place that enables the complainant to confirm the accuracy of the record of the complaint.

5. Complaint Standards Authority

We agree with the proposal to give the Ombudsman the role of Complaint Standards Authority provided that this drives improvements and consistency in complaints handling rather than simply creating another layer of auditing.

6. Extension and Reform of Jurisdiction to Healthcare

The extension of the scheme to private healthcare is likely to improve consistency. However, it is difficult to comment on this proposal fully without further detail. The majority of members of Care Forum Wales who provide health care services are commissioned by Local Health Boards to provide nursing, either in a residential care home or occasionally in someone's own home. As such we would not foresee a great impact on our members. We would, however, have concerns about any plans to introduce a fee or levy for organisations providing private care without further information and consultation given the current issues with financial stability within the care home sector.

7. Links with the Courts

We would favour any delineation or streamlining of functions that helps reduce duplication and resolution times. Complaints against the care sector can have serious reputational consequences for the provider; they can lead to lengthy suspension of staff during the process of investigation (often at odds with employment law) which is not only difficult for a business to sustain but also contributes to care practitioners and nurses leaving the sector. In principle, the ability to allow the PSOW to take over complaints from the Courts could be better for all parties, but we would not want to see further delays in resolving the complaint.

8. We would be happy to answer any further queries that the Finance Committee may have in relation to our response.

Melanie Minty

Policy Adviser, Care Forum Wales

Consideration of powers for the Public Services Ombudsman for Wales

1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

We regard the act as wholly effective and representatives of the Ombudsman have always been helpful and transparent whenever there has been any possible ambiguity about why certain decisions have been made.

2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on 'own initiative' investigations powers, which would enable the Ombudsman to initiate his own investigations without having first received a complaint about an issue. Please explain your answer.

We would have no concerns about this being introduced.

3. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

4. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

No comments

5. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.

This would be of benefit to the complainant to provide access channels of choice.

6. What other type/form of submission should be acceptable (e.g. email, website form, text messages)

Again maximising the channels of choice to the customer would be the right thing to do.

7. Do you have a view on the financial costs and benefits of this provision?

We would accept the Ombudsman's decision to accept complaints orally or via the other forms of submission stated. However, if the Ombudsman decides to accept a case, we would appreciate clear justification be provided to the Council for why he has decided to set aside the usual requirement for a complaint to be made in writing while also allowing that though the Ombudsman may have accepted the complaint, the Council may possess further information as to why a complaint had been refused originally.

8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.

Though it may be sporadic across public bodies as a whole, the majority of local authorities have adopted the model complaints policy. Cardiff Council has seen the benefit of adopting the policy and would welcome the possibility of benchmarking in the future. This would

enable the sharing of best practice to complement the work done by the All Wales Corporate Complaints Group.

9. Do you have a view on the financial costs and benefits of this provision?

No comments

10. What are your general views on the Ombudsman's current jurisdiction?

No comments

11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?

No comments

12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)

No comments

13. Do you have a view on the financial costs and benefits of this provision?

No comments

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (ie this would give complainants the opportunity to decide which route is most appropriate for them.)
15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?
16. Do you have a view on the financial costs and benefits of this provision?

We agree that complainants should be given the opportunity to decide which route is most appropriate for them. However, we would appreciate some clarification on what services would be covered by 'tribunal or other mechanism for review' should there be any conflicts with what is covered by the Council's Complaints Policy.

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

No examples held by the Council though it would presumably be the complainants who could offer comments on this.

18. Schedule 3 of the current 2005 Act, provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

No comments

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

As the current act is now being evaluated after 10 years of operation, we would suggest 5 years for the next evaluation.

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

No comments

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

No comments

22. Do you have any comments on the following issues:

- **jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;**

  No comments

- **recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;**

  As long as there remains a draft stage to a report where public bodies have the chance to comment on the Ombudsman's findings before it is finalised (in case of any discrepancies or areas of ambiguity), we have no concerns.

- **protecting the title - there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;**

  No comments

- **code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils' resolutions. Whilst a local resolution procedures exists and has been adopted by 22 local authorities, variance exists in practice.**

We would support this. The local resolution procedure has been implemented successfully at Cardiff and has been adopted by all the 22 local authorities although a variance exists in practice

23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

No comments

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

No comments

Jennifer Brown [redacted] contribution to The Finance Committee National Assembly for Wales for the Consultation into the consideration of powers of PSOW

1. PREAMBLE

1.1 As a care worker in a Carmarthenshire County Council (CCC) run care home I raised concerns about institutional abuse and criminal abuse against a service user without capacity. POVA did not handle the disclosures properly and the service user without capacity was left unprotected. Eight months after first raising the matter with the POVA manager her health was deteriorating to such an extent and knowing without her GP being made aware of the abuse she had suffered nothing would change. I disclosed to him her situation; her medical treatment was adjusted and staff were told not to force her against her will to do anything she was not ready to do. Others had also whistleblown. Because of the way our disclosures were acted on, as a group, we complained about POVA to the Public Services Ombudsman for Wales (PSOW) but he would not become involved explaining it was an employment matter. The previous year he published a report of his investigation into another whistleblower's complaint against the CCC for failures by POVA and maladministration after an abusive criminal act perpetrated on a vulnerable adult was not acted on and she continued to be left unprotected.

1.2 The Care and Social Services Inspectorate (CSSIW) told me to complain to the POVA manager as it concerned the handling of a POVA matter. The manager put the complaint into the hands of the Statutory Social Services Complaints Policy(SSSCP) manager who was advised by the internal legal department to investigate the complaint against POVA and to look into the way us whistleblowers had suffered detriment. She completed a draft report to be sent to me as I was the point of contact; I was never told of this and never received it because the Head of Service (who had been involved after our disclosures) refused to allow her to send it to me.

1.3 We whistleblowers continued to try and have our complaint investigated; I was then suspended which allowed the CCC to put the complaint into abeyance. This did not stop us trying to have the complaint looked at under the SSSCP. The CCC's own Whistleblowing Policy (WP) states a whistleblower should complain/disclose wrong doing to the manager of the SSSCP. The Welsh Assembly Government (WAG)'s guideline "Listening & Learning" (L&L) on which the SSSCP is based states complaints against POVA must first be put to the POVA manager and if complainant is not satisfied it is passed on to be investigated at stage 2 under the SSSCP; if the Local Authority is investigating itself it has to be overseen by the CSSIW (this is why I believe the CCC did not want to follow procedure as they did not want an independent body becoming involved). L&L also states that the guidelines must not conflict with the WP.

1.4 I involved the Health and Social Services Minister Lesley Griffiths who sent my letter down the ranks to the CSSIW to deal with. The CSSIW seemed to believe the CCC were investigating the complaint and they would wait to be contacted by the CCC. I had already tried to persuade the Chief Executive Officer (CEO) to use his influence and persuade the SSSCP manager to investigate giving him and the complaints manager documentation supporting the need to investigate. He did not communicate with me and seems only to have asked the Corporate Complaints manager to find out what the issue was all about. A defaming statement about me was repeated and a deliberate lie was stated to him which would have damaged my reputation and given him an excuse to do nothing even though he would have been aware I was a whistleblower. When I could see the CCC had no intention of investigating their own failures and learning lessons I sent evidence and the letter from the CSSIW to the Older Peoples Commissioner for Wales (OPCW); I don't believe any evidence was looked at as I was told, because the CCC were already investigating our complaint against

POVA they did not want to double up on the investigation. I was also told that should the SSSCP not be followed properly then I could complain to the PSOW. I did contact them again after my dismissal, just before my internal appeal against my unfair dismissal. This time they contacted the CCC and were more than happy with the response received from the POVA Manager but they did mention to me the CSSIW had become aware that the CCC seemed to have problems in relation to their handling of whistleblowers.

1.5 The CCC's WP states that if a whistleblower is not happy with the handling of their disclosures they have every right to complain to the CEO or Chair of the Standards Committee (who also oversees that the WP and SSSCP are fit for purpose). The WP also explains that instead of the former two being contacted the whistleblower could contact the PSOW or regulatory bodies if unhappy with the handling of their concerns. Before I was dismissed the internal legal advice to the SSSCP manager changed and she was told that as a whistleblower and not representing an individual service user I could not make a complaint (I was told this at my disciplinary hearing when I was unfairly dismissed). In fact before my dismissal one of the other whistleblowers had disclosed wrongdoing and neglect to management again and not being happy with the actions taken had complained to the CSSIW. They following L&L and passed the complaint on to the SSSCP manager who by then felt safe not investigating as whistleblower was not representing a service user. This is counter to the WP and the L&L. Every one of us four whistleblowers received letters to this effect several months after the complaints manager had been given this new legal advice, in fact, the day before my appeal. Of course the one whistleblower had two letters as one had to cover her latest disclosure to the CSSIW. Remembering the advice of the OPCW and having already discussed with the PSOW the situation regarding our complaint and being told I could complain to him (same time being told that this may not get me what I want; what the PSOW investigator meant by that I don't know). I filled in the PSOW's complaint form already provided to me before my dismissal by the PSOW and was given a CASE number. The same investigator was in charge of the investigation as had refused our original complaint regarding POVA. Only this time the complaint was against the CCC refusing to follow procedure and investigate our complaint against the handling of POVA.

1.6 The PSOW sent to the CCC for a response to my complaint and once again the POVA manager composed the response that was to go out from the Administration and Law Department. This response contained evidence that our disclosures of the institutional abuse etc. had been given under the WP. He also made it plain to the PSOW that I must not see that response. The PSOW was also told that I had requested a Subject Access Request under the Data Protection Act 1998 and was pursuing the dismissal via an Employment Tribunal (ET). The PSOW did not show me this response and I knew nothing about it until I was months into my ET hearings and had questioned a large portion of the CCC witnesses including the POVA Manager and was being told that the CCC had not considered me to be a whistleblower which is their excuse for not following the WP; had I had that response disclosed to me, by the CCC, it would have added weight to my witnesses statements in which they said they were told they were protected under the whistleblowing policy when interviewed in regard to the disciplinary investigation of a Night Officer.

1.7 The response explains about the Information sharing form (ISF) made by a social worker regarding my concern for the service user without capacity. I had not discussed the institutional abuse or any of the other matters I had disclosed to the POVA Manager approximately two months earlier. I had not described the full extent of the abuse she was suffering over the telephone to the same extent as I had told the POVA manager. She wrote up the ISF based on the scant information I had given her. It was this ISF that was used throughout and shown to police etc. even though two weeks later I had put all my concerns down in a statement in much more detail as I disclosed to the

POVA manager. I decided against mentioning one concern disclosed to the POVA manager as it was, at the time of that conversation, being investigated. This ISF was not altered or updated with the new criminal element inserted so the police were unaware and felt the problem was just a care management issue and not a POVA or criminal matter. I was told none of this and was only aware that the service user was left unprotected and her health continued to decline. This response contains untruths and inaccuracies; had I had a copy, with the documentary evidence I had managed to put into my bundle for the ET, I could have proved that the actions taken by the CCC against me was to cover up the fact that they had failed to follow the recommendations in the PSOW's report published in September 2009. POVA, whistleblowing and complaints policies are still not followed; all this could have been proved.

1.8 The CCC had no intention of disclosing documentation that would give credence to my claim of unfair dismissal under the Public Interest Disclosure Act (PIDA). Ordering the PSOW not to reveal the response letter and the willingness of some of their witnesses to perjure themselves showed that when that response letter was written they had already decided on the strategy to defend themselves against my claim. What I find heartening is that they did not put my disciplinary investigation officer up as a witness, instead putting the Human Resourses (HR) person who had assisted her in the investigation. On two occasions I found, in the documentation I received under Access Request, she suggests there is a need to investigate the complaint against POVA but is completely ignored. She had been given a copy of the complaint manager's draft letter that was never sent to me on the orders of the Head of Service. It was the Head of Service who chose her as investigating officer after promoting her to a post of assistant manager under the manager who was later chosen to chair my disciplinary hearing. It was also the Head of Service who'd had me suspended after realising that I intended to continue to call for the complaint against POVA be investigated. Had the investigating officer been a witness at the ET I could have used the documentary evidence which showed how she was being misled and coerced part of which was leaving out of the disciplinary investigation file (DIF) evidence which would have supported me at the disciplinary hearing. The original complaints officer, who had written the draft letter which acknowledged our complaint as being against POVA and that we were whistleblowers, assisted her in putting together the DIF. This draft letter was left out as it contradicted my being told at my disciplinary investigation meeting, by HR, the complaints team were unaware that the complaint was against POVA.

1.9 The result of the disciplinary was predetermined as before my dismissal they were discussing using the DIF as evidence against me to obtain an injunction preventing me contacting them. So much evidence I could have questioned my investigation officer on as deep down, I felt, she was an honest person but because of the culture in the CCC of cover up and denial no one would dare question what was taking place. To do so could easily cost them their positions or even their job. I believe she was not trusted by the CCC to actually perjure herself. No doubt the CCC, knowing the evidence I had on which she could have been questioned, felt the safest thing was not to follow the usual policy where the investigating officer is the main witness for the defence of a claim.

1.10 I provided the PSOW with a lot of the evidence I put in my ET bundle but whether the investigator even looked at it is not certain because about 6 months after the CCC's response letter I was told that they could not separate my complaint from my disciplinary and would discontinue investigating. It was at this time I was told about the response letter and to see it I had to fill in an undertaking not to divulge the contents. I tried to have the POVA manager recalled for questioning about this new evidence which they should have disclosed before the ET hearings. The judge refused to recall him and it was of no help with the witnesses that were left to be questioned. I appealed the PSOW's decision and as happened the last time they refused to reconsider. I was later being told by them that as a whistleblower I could not complain to the PSOW as I was not

representing a service user. I mentioned the PSOW's Report Reference Number 1999\200600720 as that arose after a complaint by a whistleblower. This time I received an answer from Peter Tyndall who explained that he had looked again at that and he now realises he should not have investigated the matter. It is strange as not long before, on television, he was saying the whistleblower in that case had been right to make the complaint to him. Like me this whistleblower was well aware that the CCC had not learnt any lessons and as our complaint would have proved the PSOW's recommendations though accepted had not being put into practice.

1.11 Recently I tweeted to @SenneddFinance @Nick_Bennett1 & @OmbudsmanWales this spread over 4 replys :- " I believe the Ombudsman lost an opportunity to force a culture change in @CarmsCouncil & it's failure to follow POVA complaints & whistleblowing policies Peter Tyndall refused to reconsider my whistleblowing complaint as not in remit!! Our W/B policy states complain to Ombudsman if disclosures not handled properly!!! IS WAG happy to allow my council to continue to act against the Public Interest???" I have put my tweets into whole words for your understanding. On March 5th same day as above @ OmbudsmanWales replied " New own initiative powers being sought by Ombudsman would have allowed us to look into this." I then tweeted 5 replies to this mentioning the above Ombudsman report which was damning to the CCC and their maladministration. I am still whistleblowing and asking the CEO to look into the matter. The Administration and Law/Monitoring officer, CEO and Chair of the Standards Committee refuse to have a meeting with me to discuss the way policies are not being followed and how there is a culture of cover up. They prefer to hide behind the fact that I lost my ET claim which in their eyes prove they followed procedures and protect the vulnerable. I sent them documentation that proved the head of Administration and Law had told the Chair of the Standards Committee in 2010 there had been no whistleblowing disclosures this contradicted evidence put in the CCC's response letter to the PSOW. "What a tangled web we weave when we practice to deceive!" .

1.12 One important piece of information left out of the CCC response letter of 25th May 2012 to the PSOW was how us whistleblowers had been told we could not complain because we were not representing a service user. I had put a copy of the letter, stating this, with the documents sent with my complaint form to the PSOW in March 2012. This response made no suggestion that as a whistleblower I could not complain and even though I had informed the PSOW of this he did not use this excuse for not investigating until I had appealed his decision. I believe the CCC and the PSOW have misused the L&L guidance to silence whistleblowers. The L&L states it must not conflict with the WP in which we are told to complain to the SSSCP manager and to complain to the PSOW if we are not happy with the handling of our disclosures. The PSOW remit is to look into the wrongful actions concerning the SSSCP. Whistleblowers are genuine complainants under the WP. Though whistleblowers are employees the PSOW would only need to investigate whatever the disclosure/complaint was about and not involve himself in the employment issue of any hardship being suffered by whistleblowers as that is dealt with under the PIDA and by the ET. ET does not look into the disclosures/complaints made by the whistleblower which caused the detriment or unfair dismissal, that is the remit of the regulators or PSOW.

2. I hope you have read my preamble and understand I am speaking from experience as a whistleblower and complainant and have had dealings with both the CCC and the PSOW. I followed the advice of the CSSIW, OPCW and the PSOW, made a complaint through SSSCP followed by complaining to the PSOW. There is no ambiguity in the L&L or in the WP. Both the CCC and the PSOW have deliberately misused the L&L to prevent an investigation that would prove the CCC has not put into practice the recommendations of the PSOW; maladministration still abounds.

Finance Committee
Consideration of powers: Public Services Ombudsman for Wales
PSOW 27 – Jennifer Brown

3. Background Paper dated 21/01/15 from PSOW

3.1 Nowhere in this document is there any mention of complaints/disclosures received from whistleblowers (employees working in public services witness wrongdoing which members of the public are not aware of but may be detrimental to their safety and interest). Listening to employee concerns is the only way of stamping out wrongdoing, cover up and maladministration. Why does it not discuss the PSOW's new decision not to investigate whistleblowing complaints as they are not in the PSOW's remit?

3.2 Own initiative investigations:-
This would no doubt be a useful tool but if it is only brought into action when a complaint has not been received it adds nothing to investigating a whistleblowers complaint as the PSOW could still fall back on his new found and wrong excuse of a whistleblower not being eligible to complain.

3.3 Access- oral complaints:-
Agree it would be of help to service user & whistleblowing (eligible?) complaints.

3.4 Complaints Standards Authority:-
The Social Services Complaints Policy & L&L WAG guidance is already statutory as he knows and to have the other complaints policies made statutory or at least his guidance would be helpful in forcing change in the handling of complaints if he really wants to hold public bodies to account.

3.5 Extension and reform of jurisdiction- Healthcare:-
In (f) what is discussed is that no public service provider has refused to implement a recommendation. He is of the opinion that, because of this, his recommendations need not be made binding on these public bodies as they are with Ombudsmen in the private sector. He deals with public bodies who accept his recommendations, who document their changes as proof they have changed their ways and learnt lessons but as I and others have witnessed the CCC changes are not acted on in practice . If they were I would not have had to whistleblow to the PSOW who, had he investigated, found the CCC had not changed it's ways in regard to POVA, whistleblowing or complaints handling since the report of 2009. My preamble did not explain everything that went on after I made the complaint against POVA in October 2010 to the POVA Manager's Office. Recommendations made to public bodies must be made binding to force improvement and accountability.

4. This is from an email trail sent from Angela Williams(CSSIW) to Ken Redman (CSSIW)dated 17/10/11 which prove a reluctance on the part of the PSOW to find proof the CCC were ignoring his recommendations:-
“SUBJECT: Our Complaint made initially over the phone to Neil Edwards's Office 22/10/10 & 25/10/10 against a POVA investigation not following it's own policy and procedures :
Ken-I routinely get copied into Mrs Brown's correspondence and as you know last year undertook a detailed stage I investigation into her concerns about CSSIW's role. We met to discuss the lessons learned from that. Things have progressed from that point and Mrs B went to the Minister- see my response attached- and is now following the proper channels (not without difficulty it seems however).
I am copying you in for 2 reasons:
1)That we may be contacted by the investigating officer- my letter attached refers (stage 1 of the LA procedures I believe)
2)We need to be aware of this from the LA perspective and consider carefully how we link this into our forthcoming meeting with the council in Nov. My belief is that they should put this in the

hands of a credible independent investigator and escalate to stage 2. The Ombudsman is trying not to be involved at this stage-rightly so- given that the LA side of things needs to be given a fair chance to progress. It seems not to have made much headway however and it may be this we need to discuss with them." Why was the PSOW indicating a reluctance at that stage before my complaint of 2012?

5. If the CCC & PSOW are right no employee in social services would be able to whistleblow in the public interest. Their interpretation is counter to L&L & WP. Why does the PSOW want to silence us? I can understand defensive, unaccountable public bodies doing this but not Ombudsmen who are there to protect the public interest. The PSOW must not be allowed to refuse to accept whistleblowing complaints as has happened in my case. Was it to protect the CCC or itself?

MOLD TOWN COUNCIL
CYNGOR TREF YR WYDDGRUG

www.moldtowncouncil.org.uk

National Assembly for Wales – Finance Committee – 20 March 2015

Amendments to the Public Services Ombudsman (Wales) Act 2005

Consultation Questions – Response from Mold Town Council

Own initiative investigations

Q. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on „own initiative‟ investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.

A. The Town Council would support the idea of “own initiative” in principle, but would wish to see assurances that there are “checks and balances” in place to ensure the PSOW do not exceed their new powers.

Q. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman’s responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

A. This would be linked to our response (above). If a monitoring process was in place this would reduce the likelihood of over lapping responsibilities.

Q. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

A. The Town Council is not in a qualified position to be able to respond to this question

Oral Complaints

Q. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.

A. The Town Council do not support the proposal for oral complaints unless a statement can be taken, witness and signed by all parties, such as Police statement procedures.

Q. What other type/form of submission should be acceptable (e.g. email, website form, text messages)

A. The Town Council supports all electronic formats, but would wish to see the introduction of electronic signatures.

Q. Do you have a view on the financial costs and benefits of this provision?

A. It is likely that there would be additional costs incurred if procedures were in place for witness statements; however there could be savings on electronic statements.

Complaints handling across public services

Q. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.

A. The Town Council supports the idea of a complaints policy which public bodies would be obliged to adopt. It would create a standard process across Wales for all public bodies which the public would understand.

Q. Do you have a view on the financial costs and benefits of this provision?

A. The Town Council is not in a qualified position to be able to respond to this question.

Ombudsman's jurisdiction

Q. What are your general views on the Ombudsman's current jurisdiction? At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather

than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?

A. The Town Council support the proposals to extend the Ombudsman's jurisdiction.

Q. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)

A. The Town Council would support charging on a case by case basis.

Q. Do you have a view on the financial costs and benefits of this provision?

A. The Town Council is not in a qualified position to be able to respond to this question.

Links with the courts

Q. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (i.e. this would give complainants the opportunity to decide which route is most appropriate for them.)
A. The Town Council supports this idea.

Q. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?

A. As with the response above, this would go hand in hand with the earlier question.

Q. Do you have a view on the financial costs and benefits of this provision?

A. The Town Council is not in a qualified position to be able to respond to this question.

Other issues

Q. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

A. N/A

Q. Schedule 3 of the current 2005 Act provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

A. N/A

Q. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

A. The Town Council would suggest that the evaluation should be on a three yearly basis.

Q. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

A. There is a risk that the PSOW could become to powerful without recourse.

Q. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

A. The Town Council is not in a qualified position to be able to respond to this question.

Q. Do you have any comments on the following issues?

a) jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;

b) recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;

c) protecting the title - there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman?

d) code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils" resolutions. Whilst a local resolution procedure exists and has been adopted by 22 local authorities, variance exists in practice.

A. a) This could be address through a three yearly review.
b) Yes, the recommendations of the Ombudsman to public bodies should be binding.
c) Yes, they should gain approval from the Ombudsman.
d) The Town Council agrees.

Q. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

A. N/A

Q. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

A. N/A

The Holywell Town Council has resolved :

1. Not to support the following proposals relating to

Own-initiative powers;

Oral complaints.

2. To support the following proposals relating to

Complaints handling across public services;

The Ombudsman's jurisdiction;

Links with the courts.

Additional comments:

Evidence presented should be subject to same tests as in the law courts.

The opportunity for appeal against the Ombudsman's decision on specified grounds should be considered.

D.C. Pierce

Town Clerk and Financial Officer

Consultation Questions

1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

   The Act is generally fit for purpose

Own initiative investigations

2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on „own initiative" investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.

   There is no objection in principle to this provision. There is logic in the Ombudsman being able to extend an existing investigation to cover other fields without a separate referral. An example would be where a complaint is received about Social Services whereas the responsibility lay with the Health Service. It makes sense for the Ombudsman to then investigate the Health Service without a separate complaint being made.

3. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman"s responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

This is a danger and there would need to be guidelines so that in the event of a complaint being extended to an organisation which already had an independent complaints system, that organisation's system should either take preference or should work in conjunction with the Ombudsman in any investigation

4. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

   The Ombudsman's office does not respond to complaints in a timely manner in all cases. A recent Code of Conduct investigation took 12 months to complete. The own-initiative provisions should be a last resort where the public interest strongly suggests that such an investigation should take place otherwise these investigations would take place at the expense of its existing workload

Oral Complaints

5. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.

This is a good idea in terms of inclusivity. Our own internal complaints policy allows for complainants to submit oral complaints. Not everyone is confident enough to submit something in writing and by allowing oral complaints it ensures that no part of society is disadvantaged

6. What other type/form of submission should be acceptable (e.g. email, website form, text messages)

All should be accepted but with safeguards around identity checks so that malicious complaints are not made in another's name

7. Do you have a view on the financial costs and benefits of this provision?
This should not have a financial cost and could lead to increased efficiency. Some complaints may reach the Ombudsman's office at present in an incomprehensible form and this would be eliminated/reduced

Complaints handling across public services

8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.

Most Local Authorities in Wales have already adopted the model complaints policy in principle. There is no objection to it being rolled out further

9. Do you have a view on the financial costs and benefits of this provision?

There should not be a great cost

Ombudsman"s jurisdiction

10. What are your general views on the Ombudsman"s current jurisdiction?

It seems to work

11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman"s jurisdiction in this way?

Agree

12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)

No strong views on this

13. Do you have a view on the financial costs and benefits of this provision?

No strong views on this

Links with the courts

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (ie this would give complainants the opportunity to decide which route is most appropriate for them.)

Totally opposed to this. The current bar is a safeguard for Local Authorities. A situation could arise where a complainant chose the Ombudsman route and then afterwards proceeded with litigation, using the Ombudsman's ruling as evidence when the same level of scrutiny would not be applied in the two processes. It is also difficult to see how the Ombudsman could be resourced to undertake the inevitable increase in workload which this provision would bring.

Whilst there is an argument that some people do not get justice because of the costs of going to Court, there is a strong counter-argument that a free service such as this would encourage litigious and vexatious complainants to pursue issues of no merit

15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?

No great objection

16. Do you have a view on the financial costs and benefits of this provision?
There would of course be a cost and presumably this would not be something which would done lightly or often

Other issues

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?
No – the consultation seems to be around "nice to haves" rather than essentials. Personally I would prefer to see the Ombudsman's office focussing on increasing the speed of their current investigations. Taking on further work without added resources can only put greater strain on those services and in these times of austerity I cannot see the justification in expanding the Ombudsman's remit

18. Schedule 3 of the current 2005 Act, provides a list of authorities that are within the Ombudsman"s jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?
None

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?
Once implemented it is difficult to see the merits of any evaluation

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?
A strain on resources

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?
An analysis of the impact of these proposals on existing procedures and investigations particularly in terms of timetable

22. Do you have any comments on the following issues:

- jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman"s jurisdiction;

This should be an ongoing review as further powers are devolved

- recommendations and findings – should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;

Provided that the body had had an opportunity to consider the draft findings as at present then this is supported

- protecting the title – there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;

No views on this

- code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils" resolutions. Whilst a local resolution procedures exists and has been adopted by 22 local authorities, variance exists in practice.

There should be tougher responses to "tit for tat" complaints particularly in Town and Community Councils. Monitoring Officers should not become involved in Town and Community Councillors' disputes other than in their present role following a referral to Standards Committee from the Ombudsman

23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?
No

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?
I have concerns around persistent and vexatious complainants. They can and do refer Members to the Ombudsman on more than one occasion and totally without merit. There seems to be no filter in terms of complaints in the Ombudsman's office where a holding letter will be sent out to inform the Member that the complaint has been received and that a decision will be made as to whether to investigate. Invariably, no investigation follows. When the complaints are so obviously without merit (and these vexatious persons must be known to the Ombudsman), why can't the Ombudsman dismiss the claims at the outset rather than have this two stage process.

Please see the following joint response of the Brecon Beacons and Pembrokeshire Coast National Park Authorities to the consultation on an inquiry into the consideration of powers of the Public Services Ombudsman for Wales

Consultation Questions

1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

Reply

1.1 In general terms, the Act works well, but I do have concerns that the increase in the extent and workload of the Ombudsman has not been met with a commensurate increase in funding and that in order to ensure that the very high quality work that is currently undertaken in such a broad jurisdiction can be maintained in the future

Own initiative investigations

2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on „own initiative" investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.

Reply

2.1 As was set out in the Ombudsman's evidence to the Finance Committee there is a case made out for this. I considered to be appropriate, as it is clearly accepted practice in many countries in f Europe and beyond and so I support the view of the Ombudsman being able to extend the area of his investigations into associated or related bodies, as these emerge during the course of an investigation. There will need to be serious thought given to the drafting of appropriate safeguards and caution will need to be exercised to avoid the potential for duplication of work by other statutory bodies such as the Wales Audit Office.

3. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

Reply

3.1 Yes, please see below. There needs to be clear safeguards to avoid duplication.

4. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

Reply

4.1 In dealing firstly with the proposed financial costs I do not consider these to be excessive when bearing in mind the nature of the investigations that are likely to be undertaken. As I have already referred to in the reply above, there will need to be clear safeguards and caution exercised with regard to potential duplication.

I believe these can be overcome with clear protocols and guidance given both to the Ombudsman and other relevant public bodies. This should be a matter of concise, drafting and clear boundaries being established and agreed. This should not be insurmountable.

Oral Complaints

5. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.

Reply

5.1 There is a difference between complaints from those who are unable to read and write in either English or Welsh, where the Ombudsman should be able to accept complaints orally, in contrast to those who can but simply do not choose to put their complaint to the Ombudsman in writing. It should not be too difficult to establish a procedure whereby any oral complaint , which is made by a person who may have literacy challenges ,is properly and accurately set out.

5.2 A simple template could be used and complaints could also be received in electronic form quite easily.

5.3 I believe it is important that the body that is the subject of the complaint should know exactly what the complaint is about so it can deal with it in an appropriate fashion as promptly as possible. The danger with all complaints being made orally, is that there can be confusion at the outset as to what exactly the complaint is about..
Provided that the oral complaints and the electronic recording of the complaints received can be managed effectivel, I do not see any reason why the current system should not be adapted to the receipt of oral and other forms of electronic media l complaints .What is the important issue ,is that the complaint is clear so all parties concerned know what it is.

6. What other type/form of submission should be acceptable (e.g. email, website form, text messages)

Reply

6.1 Email, text messages and website form should all be acceptable.

7. Do you have a view on the financial costs and benefits of this provision?

Reply

7.1 As it is envisaged that there will be no cost implications. I have no comment.

Complaints handling across public services

8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is

voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.

Reply

8.1 *As is clear from the evidence from the Ombudsman, considerable progress has been made with regard to establishing a consistent standard for public service providers across Wales with regard to complaints. I agree with his analysis that the problem lies with the enforcement and that is why the Scottish Ombudsman's arrangement which is tried and tested , should be adopted in Wales.*

9. Do you have a view on the financial costs and benefits of this provision?

Reply

9.1 *The financial costs seem relatively modest to ensure that all the citizens across Wales to receive the same sort of treatment when making complaints and public bodies. There is clearly both an educational role and the regulatory role which has been recognised the fact that into the costs. This is to be supported.*

Ombudsman's jurisdiction

10. What are your general views on the Ombudsman's current jurisdiction?

Reply

10.1 *Clearly, after 10 years, it is appropriate for a review to taken place and some current anomalies and "wrinkles" ironed out. In the current jurisdiction, it has become apparent that there are one or two gaps which need to be plugged. But in the widest analysis the current jurisdiction appears to be covering most the relevant areas, that can be covered within the limited budget available. Health and housing are key components , when looked at from a Welsh demographic.*

11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?

Reply

11.1 *This is beyond the remit of the National Park Authorities at present, so any comment is passed in relation to the general concept of "Well-being " which is in its widest sense ,part of the remit for the inhabitants, and users of the National Parks. This extension is to be welcomed and should be supported for the reasons given by the Ombudsman in his evidence to the Committee.*

12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)

Reply

12.1 I do not think it should be the subject of a levy or a charge upon any individual who makes a complaint. If it transpires that the complaint is well founded then consideration may be given to how the costs of the enquiry can be recovered from the private healthcare company or provider concerned. This is a principle that is often adopted in the case of the enforcement of environmental breaches by regulatory authorities against organisations and individuals whose conduct has led to a significant investigation having to be undertaken by a public body, when it is established that they have been at fault. Much more thought will need to be given as to the detail of this however, the principle should be supported.

13. Do you have a view on the financial costs and benefits of this provision?

Reply

13.1 The financial provisions for this somewhat sparse and again will require much greater thought has been provided at the moment.

Links with the courts

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (i.e this would give complainants the opportunity to decide which route is most appropriate for them.)

Reply

14.1 Notwithstanding the views of the Law Commission, I believe there are significant legal hurdles would have to be overcome for this to be effective.

14.2 I believe is a significant issue with regard to the Welsh government's own competence in this area, which only need to be resolved before the matter can be taken any further.

14.3 If it is decided to take this matter further, then again further consideration will need to be given to this proposal, as there are quite clearly different procedures which are used in courts from those used by the Ombudsman, specifically in relation to evidence, the right to cross-examine witnesses and disclosure of relevant documents to all parties. This does not appear to have been as well thought out on a practical level as other aspects of this consultation.

14.4 As presently drafted the proposal does not seem to show any real evidence to support it, other than a reliance on the Law Commission's view. The adoption of such a proposal would also need detailed rules, protocols and in all probability a Practice Direction to be adopted by the Civil Procedure Rules Committee of the Ministry of Justice before any implementation. There is no evidence that any consideration has been given to this. There is also little evidence to support the view that there is an actual prejudice that has become clear and obvious to parties, as things stand now.

14.5 There is no evidence the Courts would accept the premise that a shadow body will be dealing with the same case , under different procedures.

15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?

Reply

15.1 This may be useful in a limited number of cases and could be relatively easily introduced. I believe. The number of cases is likely to be small and would not require a major jurisdictional change , unlike the broader earlier proposal.

16. Do you have a view on the financial costs and benefits of this provision?

Reply

16.1 From drawing on my experience as a practising lawyer for 40 years, and sitting as a part-time judge deals with legal costs cases (amongst others).in my opinion this is likely to be a significant underestimate and reflects probably the costs that would be incurred in perhaps just one case per year. The scheme should be very carefully costed out, based upon analysis from the Supreme Court, Costs Office as to the average running cost of cases heard in the Administrative Court. No such evidence has been provided.

16.2 With regard to this particular proposal. I consider that much greater care, thought and evidence is required before it is adopted.

Other issues

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

Reply

17.1 Not personally

18. Schedule 3 of the current 2005 Act, provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

Reply

18.1 None come readily to mind, who are not already on it.

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

Reply

19.1 Two years should be sufficient period

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

Reply

20.1 The principal problem that I foresee is that the proposed removal of the statutory bar which prevents the Ombudsman, from considering a complaint with the case could or has been considered by the courts, needs far greater consideration. This will require far more detailed evidence to be submitted, as to the need for a change in practical terms, the cost and resolving what appears to be significant jurisdictional matters. This could ultimately lead to expensive and somewhat pointless litigation , this could be avoided by not hastily incorporating this provision into legislation.

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

Reply

21.1 The number of complaints that have been resolved, the confidence of citizen's in a system that is integrated and able resolve complex interrelated complaint involving a number of different public bodies. There is also a potential for cost saving in avoiding duplicate enquiries and investigations, particularly in the health field.

22. Do you have any comments on the following issues :
    - jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;

Reply

22.1 This will depend upon what changes are actually implemented. But in general, great care should be avoided in proliferating organisations and bodies which may duplicate the role of the Ombudsman.

    - recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;

Reply

22.2 The public bodies concerned do need to have the right to challenge any findings made by the Ombudsman, although in practice, there does seem any appetite for this. Nevertheless, there may be such cases which do arise in the future and that does need for there to be a safeguard or check and balance in place, and so it should be retained .To remove this is effectively removing any right of appeal and the perception of being both judge and jury. It should nevertheless, be reviewed so that any challenge or decision to reject any findings ,by the public body concerned , has to be made on clearly set out guidelines, which have been drafted after widespread consultation.

- protecting the title - there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;

Reply

22.3 *Yes. The reputation of the Ombudsman has been built up very carefully and appears to generally enjoy weightlifting support from both complainants and public bodies. This should be no scope for confusion in the minds of citizens, and accordingly the protection of the title is essential.*

- code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils" resolutions. Whilst a local resolution procedure exists and has been adopted by 22 local authorities, variance exists in practice.

Reply

22.4 *The retention by the Ombudsman of Code of Conduct complaints, in my experience too, plays an important part in the credibility of the scheme. I do recognise that it may be beneficial for the future to ensure that fewer complaints remain actually with the Ombudsman and more can be referred back to the Monitoring Officers for investigation and disposal through the relevant Standards Committees.*

22.5 *The introduction of the local resolution procedure in the two National Park Authorities which I am concerned , has been a beneficial development, although neither hast actually been called upon to do anything, I am satisfied that Members are aware now, that the complaints of the type that used to be quite common will now be dealt with more locally, more quickly and more robustly .I am satisfied that some in the past were politically motivated and created a real danger of bringing the system into disrepute.*

23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

Reply

23.1 *None at the moment*

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

Reply

24.1 *I would like to see the rules for the Adjudication Panel revisited so that it can be able to discharge its duties, without some of the limitations that exist upon it at the moment. In particular, is a danger I believe that this body is being over used by lawyers in a way that was not envisaged at its inception and that its original purposes have become inextricably entwined with overly complicated legal submissions and disproportionate legal costs causing a real prejudice to the*

Ombudsman in particular. The costs limitation is one step towards restoring a level playing field but more needs to done.

John Parsons
Monitoring Officer
Brecon Beacons NPA
Pembrokeshire Coast NPA

Consideration of powers for the Public Services Ombudsman for Wales

Response from the Standards and Ethics Committee – City of Cardiff Council

1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

We regard the act as wholly effective. We have had concerns in the past about delays in dealing with member complaints but performance in recent times has greatly improved . We remain concerned that the proposed changes would result in a significant increase in running costs – approximately 5-6% per annum. Is this affordable in the current financial climate? Is it possible to link this increase to cost reduction opportunities within the proposed changes?

2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on 'own initiative' investigations powers, which would enable the Ombudsman to initiate his own investigations without having first received a complaint about an issue. Please explain your answer.

The principle of this is acceptable and looking at the examples given and comparing with the investigations carried out by the Local Authority this would not affect our current procedure.

Own initiative investigations should be by exception and/or where there are opportunities to tackle wider ranging issues which affect a large number of public service organisations. If this new power is implemented, it should ensure that it does not duplicate resources or intervene where the organisation is capable of investigating the matter effectively using its own resources.

In advance of initiating an investigation, sufficient engagement should take place with affected parties and other organisations that may have relevant responsibilities.

There should be clear guidelines and criteria developed, in consultation with public service organisations, as to when an own initiative can or should be launched.

The potential cost implications should be assessed at the outset of any own initiative investigation and weighed against the potential benefits

3. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

Please see comments above at 2

4. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

Please see comments above at 2

5. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.

It is essential that the Public Service Ombudsman is accessible to all. Accepting oral complaints contributes to this but also allowing complaints thought digital means by email and web form will enable better access.

If there is evidence to suggest that there will be a significant proportion of oral complaints, there will be time and cost implications and there will need to be the capacity to handle these. Perhaps, there may be some value in identifying an intermediary/independent person who can be assigned a specific remit for providing practical support to those who need it (e.g. Complaints Wales, Citizen's Advice Bureau), to progress a complaint. This could prove useful in filtering the direct enquiries received by the Ombudsman and provide practical support to complainants that need it.

Digital technologies (email and web) should be used to their maximum effect to improve the efficiency of the complaints process. The Ombudsman is currently very outdated in this respect. Those who can use digital methods should be encouraged to do so by communication via the Public Service Ombudsman website and other public service bodies.

We also wish to stress that there also needs to be a variety of different channels of making complaints available as using technology alone is likely to affect those people from more deprived backgrounds who may not have access to such technology (or skills to exploit it).

6. What other type/form of submission should be acceptable (e.g. email, website form, text messages)

Again maximising the channels of choice to the customer would be the right thing to do.

7. Do you have a view on the financial costs and benefits of this provision?

Please see comments above

8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.

We should aim for standardisation of the complaints policy across public service organisations, with a view to reducing administration costs, enabling greater efficiency and using a model of best practice. However, it is also important to recognise that some organisations will have differing powers and resources, which will need to be taken into consideration.

A Model Complaints Policy already exists and most Unitary Authorities follow this approach. Any change that can enhance this by sharing of information and performance improvements should be supported and, therefore, bring greater benefit to all public services.

9. Do you have a view on the financial costs and benefits of this provision?

Please see comments above at 8.

10. What are your general views on the Ombudsman's current jurisdiction?

No comments

11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?

Whist we can see the value of processes following the citizen rather than the sector, we remain concerned that permitting the Public Sector Ombudsman to move into investigating complaints of healthcare services not commissioned by the NHS would be outside the scope of an Act concerned with public services.

We suggest that consideration be given to extending the remit of the Parliamentary Health Service Ombudsman to cover the private healthcare sector. Given the significant financial cuts being experienced by the public sector, is it reasonable to plan for potential additional costs to the public sector of £50,000?

12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)

No comments

13. Do you have a view on the financial costs and benefits of this provision?

No comments

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (i.e. this would give complainants the opportunity to decide which route is most appropriate for them.)

Complainants must have options available and any changes that supports this are acceptable

15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?

We would support this

16. Do you have a view on the financial costs and benefits of this provision?

We agree that complainants should be given the opportunity to decide which route is most appropriate for them. However, we would appreciate some clarification on what services would be covered by 'tribunal or other mechanism for review' should there be any conflicts with what is covered by the Council's Complaints Policy.

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

No examples held by the Council though it would presumably be the complainants who could offer comments on this.

18. Schedule 3 of the current 2005 Act, provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

No comments

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

As the current act is now being evaluated after 10 years of operation, we would suggest 5 years for the next evaluation.

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

No comments

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

No comments

22. Do you have any comments on the following issues:

- **jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;**

  No comments

- **recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;**

  As long as there remains a draft stage to a report where public bodies have the chance to comment on the Ombudsman's findings before it is finalised (in case of any discrepancies or areas of ambiguity), we have no concerns.

- **protecting the title - there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;**

  No comments

- **code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils' resolutions. Whilst a local resolution procedures exists and has been adopted by 22 local authorities, variance exists in practice.**

We would support this . The local resolution procedure has been implemented successfully at Cardiff and has been adopted by all the 22 local authorities although a variance exists in practice.

23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

No comments

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

No comments

Richard Tebboth

Independent Chair of the Standards and Ethics Committee

Cardiff Council

19 March 2015

INQUIRY ON THE PUBLIC SERVICE OMBUDSMAN FOR WALES

Dr Richard Kirkham, School of Law, University of Sheffield

Some introductory comments

1. As well as writing extensively on the Ombudsman, I was a member of an independent evaluation panel for the Local Government Ombudsman in England in 2013 (*External Evaluation of the LGO*).

2. The administrative justice system, and indeed the civil justice system, in Wales and the UK is an evolving network of processes and institutions. It is also one in which less and less reliance can be placed on the courts and the structures and processes that support them to deliver universal 'justice'.

3. Ombudsman schemes, and ADR more generally, have been exposed to criticism, and some aspects of that criticism are justified. But, the potential benefits of this model of dispute resolution are significant and, as the EU Directive on ADR emphasises, the trend towards ADR looks set to continue.

4. The ombudsman enterprise remains relatively young and the processes employed are still being refined. In particular, there is still work to do to raise the profile and robustness of ombudsman schemes.

5. Finally, the landscape within which the ombudsman operates is changing rapidly due to developments in information technology, the merging of the public and private sectors and the pressures of austerity politics.

6. With all these factors in mind, this review and set of proposals is a model of good practice in helping to strengthen the potential of the ombudsman to both resolve complaints and increase administrative justice.

Q1

7. The current 2005 Act has facilitated a robust ombudsman scheme and within the UK there are a number of schemes that would benefit from using the Welsh model as a starting template.

***Q2-4 & 17**: Own initiative investigations* (OII)

8. An ombudsman scheme should have powers of own-initiative investigation (OII) for the reasons outlined by the PSOW; note too the additional evidence provided by the PSOW of good use being made of OIIs elsewhere. In research conducted a few years ago in Australia and New Zealand, my colleagues and I found universal agreement amongst ombudsman schemes that the role could not be performed properly without the capacity for OII.

9. The OII power offers the potential for an ombudsman to investigate systemic maladministration before it becomes a long-lasting and large scale problem. In some circumstances, it provides the opportunity for the redress of grievances that in all probability would not lead to a complaint because of the nature of the aggrieved individual (eg they are young, vulnerable, in care).

10. The circumstances when an OII would be required would, I anticipate, be rare. Most forms of grievance come about as a result of highly individualised

fact patterns. But the history of ombudsman work provides much evidence of systemic maladministration in the provision of public services which goes beyond the individual complaint. Currently, legislation makes it difficult for the PSOW to investigate such wider maladministration, accept in confined circumstances. By contrast, the OII power would create the framework within which the PSOW could provide a more powerful and relevant service.

11. There are potential risks in introducing such an OII power to Wales, but these can be managed through legislation and proper oversight. Eg:

Danger of overuse of the OII power to the detriment of complaint-handling

12. The power of OII could dominate the work of the PSOW to the detriment of its other roles, but it is highly unlikely. The EU Ombudsman, which is a relatively large scheme, and the Ontario Ombudsman in Canada have both made extensive use of the power. But these schemes are exceptions to the rule, for elsewhere the OII power is used sparingly.

13. The scrutiny of the Assembly for Wales is adequate for gauging whether or not a PSOW is overusing or inappropriately implementing the OII power. The Assembly should not have any power to intervene in an OII once an investigation has been commenced. But it should have a role in scrutinising the output of the PSOW. Given this, the PSOW will be wary of pursuing a strategy with regard to OIIs which it could not defend or gain the long-term support for from the Assembly. Should the process of scrutiny lead the Assembly to have concerns about the office's use of the power then it would be open to it to amend the PSOW's legislation in the future.

14. Further, the exercise of the OII power will come with financial and human resources/research costs. The PSOW has offered an initial costing of the resources to be employed in this capacity. Given current budget constraints (and the rising numbers of complaints that the PSOW receives), it is unlikely that a PSOW would choose to use this power other than as a reserve tool to be employed as and where necessary.

Might a PSOW inappropriately use the OII power?

15. The PSOW could take on inappropriate OIIs or be tempted into OIIs on the back of Government, political or media pressure, which in the long-term might raise a significant reputational risk. It might even lead to the loss of good will with the administration and/or the public and the Assembly. A linked concern is that the power of OII might lead to over-scrutiny or duplication of efforts with regulatory bodies, or that 'fishing expeditions' might be initiated without clear evidence of administrative wrongdoing.

16. These are risks, but they are risks that already exist for standard large scale investigations that ombudsman schemes sometimes put in place following a series of similar complaints. See for instance the work of the UK Parliamentary Ombudsman into *Occupational Pensions* and *Equitable Life* during the 2000-2010 period.

17. Such concerns are not, therefore, strong arguments against the OII power, but they are reasons for ensuring that the power is accompanied by a robust and transparent process ie:

- The PSOW should be required to consult before commencing (or closing) an OII and give reasons. For instance, legislation might express the power as one to be used 'where the PSOW is of the opinion that it is in the public interest to commence an OII having first consulted with relevant parties, including the Auditor-General for Wales and any relevant regulatory body'.
- On the conclusion of an OII, the PSOW should be required to submit a report direct to the Assembly, although it may also be required to send a copy to a Minister and any organisation impacted by the report.
- Within an appropriate time-frame, any relevant bodies the report has made recommendations about should be required to inform the PSOW of their response to the recommendations. Should the relevant bodies decline to implement the recommendations in whole or in part then they should be required to provide reasons.
- Should the relevant bodies decline to implement the recommendations then the PSOW should have a power to issue a further report.
- Finally, the Assembly should, as a matter of practice, dedicate a select committee (presumably the Finance Committee) to considering the report and, where necessary, hold an inquiry on the matter, including consideration of the effectiveness and appropriateness of the report.

Might the OII power interfere with the responsibility of providers?

18. In the past it has been argued that the OII power would curtail a public authority's lawful discretionary power, or may lead to a prescriptive set of recommendations as to how a particular administrative process is managed, including on the policy behind that process.

19. Such a concern though misunderstands the work of the PSOW. The authority of the PSOW rests on the quality and accuracy of its findings, the appropriateness of its recommendations and its ability to retain support amongst key stakeholders, including the Assembly and the Government. Within this process, the public authority does retain the right to exercise its full discretionary power, the only restriction is that it must do so according to standard administrative law grounds (which include responding rationally to the PSOW report) and the political need to be able to defend its actions.

20. To conclude, therefore, use of the OII power would increase the burdens on a public authority subject to an OII, but it would not remove the responsibility to act from the authority concerned. Given the importance of the issues that would no doubt underpin an OII, within a constitution committed to accountable government and continual improvement in administration, this is an appropriate balance.

21. The proposed extra financial costs appear realistic and indicate an intention not to overuse the OII Power in the short-term. In practice, I would

expect the PSOW to operate a flexible office within which staff would be shifted in and out of OII work as demand requires.

22. The benefits that may be gained through OIIs will be very hard to quantify, but will include: extended redress; improved access to administrative justice; more frequent systemic recommendations on improving administrative performance; and potential long-term financial savings from improved administrative performance.

Q5-7: *Oral Complaints*

23. The type/form of submission by which complaints are made should be left to the discretion of the PSOW, including whether to accept oral complaints. One of the key demands on ombudsman schemes today is to provide a better service to the complainant, with expectations increasing all the time in part because of technology advances. In order to allow the PSOW to improve the quality of its service it should be given the flexibility to innovate.

24. The EU has passed a Regulation on Online Dispute Resolution and it would be advisable for the Welsh legislation to be written widely to ensure that it remains in compliance with developments in this area.

25. So long as the legislation is not too prescriptive, the PSOW will be able to devise suitable filtering mechanisms to ensure that it is not overrun with complaints that require investigation. Ombudsman schemes already have sophisticated processes in place to protect the system from abuse.

Q8-9: *Complaints handling across public services*

26. There is a growing body of evidence (eg the Public Administration Select Committee's report into complaint handling in 2014) to suggest that the complaints system set up in the UK is excessively complex. The Welsh model pioneered by the PSOW offers a powerful potential solution and the powers of the Scottish Public Services Ombudsman would map very nicely onto the PSOW. I would also advocate making it a statutory duty of public authorities to have a complaints process in place; for that process to be advertised to service users; and for the throughput of the complaints process to be reported to the PSOW on an annual basis.

Q10-13: *Ombudsman's jurisdiction*

27. Wales is in a strong position in that it has just one ombudsman service for the public sector as a whole. As a matter of general policy, this unified model should be built upon. It is widely understood that a model of public service provision that involves increasingly integrated governance across the public/private boundary has become pervasive. This model should be reflected in a complaint process which is flexible enough to oversee complaints that cross over traditional public service boundaries.

28. I am in favour of the limited extension of the PSOW's jurisdiction to self-funded private healthcare. As a matter of good practice, private healthcare

providers should be linked to an independent complaints process as well as judicial scrutiny. The PSOW's proposal would appear an efficient solution.

29. As a matter of principle, I would consider charging on a case by case basis, with the potential for added costs for non-compliance to the PSOW's recommendations. But the PSOW himself has suggested that this would be disproportionate given the low number of such complaints anticipated.

Q14-16: Links with the courts

30. It is unclear to me that the statutory bar any longer serves a meaningful purpose and it possibly sends out the wrong message. Both the courts and the ombudsman have sufficient discretion and incentive to filter out claimants attempting to seek redress through both forums. I would support the Law Commission's 2011 proposals, but whether this is a major problem given the existing discretion of the PSOW to accept complaints is unclear.

31. The power to refer a legal question to court could be useful in certain, rare circumstances and I would support the proposals of the Law Commission in this area in its 2011 report. For instance, the court ruled in *Argyll and Bute Council, Re Judicial Review of a Decision of the Scottish Public Services Ombudsman* [2007] CSOH 168 that in producing her report the Ombudsman had misinterpreted the law. The law in question was vital to the Ombudsman's finding of maladministration. In similar instances, the ombudsman may be able to avoid the legal question altogether and find an alternative basis by which to establish maladministration, but this will not always be possible. Nor is it always possible for the ombudsman to identify the point of law that requires interpretation when the complaint is first submitted and so refuse to investigate (a point accepted in *R v Local Commissioner for Administration, ex parte Liverpool City Council* [2001] 1 All ER 462). Thus there will be occasions when during the course of an investigation the ombudsman is forced to address a difficult question of law.

32. But to implement this proposal just in Wales would impact on the practice of the courts in England and Wales, and may as a result be outside the jurisdiction of the Assembly.

Q18-24: Comments on the other issues

33. Regardless of the proposed new powers, on a regular basis the Assembly should be undertaking a rigorous evaluation of the PSOW, including its legislation. Such a review should go beyond the review of an Annual Report and might be based upon a commissioned independent study. Such broader Assembly evaluations of the PSOW might be planned to dovetail with the fixed terms of each office-holder (ie once every 7 years).

34. For a number of reasons, the recommendations of the Ombudsman to public bodies should not be binding. At present, most ombudsman schemes express satisfaction with the very high implementation rates of their recommendations and the common law has recently shifted to give strong legal force to their findings. However, as more complaints are received on public service matters which are provided by private sector organisations

this is an issue that may have to be reconsidered in the future for those bodies which are not subject to political accountability regimes.

35. The Assembly could be obliged to consult with the PSOW when creating new bodies, to avoid the title 'ombudsman' being used inappropriately.

36. The code of conduct complaints role is a difficult one for an ombudsman to perform given its potential to draw the PSOW into issues that lead to a local authority losing trust in the institution. One option might for the role to be transferred to the Commissioner for Standards which performs a similar role in regard to the Assembly.

Dear Committee Clerk,

Thank you for consulting us on this matter. I enclose Carmarthenshire County Council's views.

Consultation Questions

1. We have no issues with the effectiveness of the Act.

Own initiative investigations

2. We are against this proposal. In our view issues for investigation should be complainant led. The Ombudsman already has the power to expand an investigation beyond the matter complained of, as well as being empowered to look at not only how the complainant has been affected but also others, and we feel that this is sufficient jurisdiction.

3. Yes. We believe Authorities are subject to sufficient regulation without adding a further tier through "own initiative" investigations.

4. We consider that this would have the potential to increase the costs burden on local authorities.

Oral Complaints

5. We are against this proposal. A complainant should accept ownership of their complaint and be expected to invest a certain amount of time and effort in framing the substance of their complaint. Expecting an officer in the Ombudsman's Office to capture the essence of a complaint from a verbal account would leave the nature of the complaint open misinterpretation, and lack of true detail. There appears to be no compelling evidence to show that the current system of requiring complaints to be made in writing is not working.On the contrary: according to the Ombudsman's own Annual report for 13/14 there has been a significant increase in the number of complaints across a range of Authorities falling within his jurisdiction, this increase being a continuation of the trend.

6. We accept that complaints processes have to move with the times, but we are concerned that allowing complaints to be made by text will lead to complaints being fired off without appropriate thought being given to them, and the substance of the complaint may not be fully put and abbreviated and limited by character restrictions on message lengths.

7. Will inevitably lead to greater cost.

Complaints handling across public services

8. We support this proposal, and we have already long since adopted the Ombudsman's model policy.

9. No views to offer.

Ombudsman"s jurisdiction

10. No views

11. We support this proposal.

12. No comment.

13. No comment.

Links with the courts

14. We are strongly opposed to this proposal. Where a complainant has had recourse to law and lost his or her case the Court's decision should be final; where a complainant has recourse to the Courts that is where he or she should fight the case, especially as such cases will inevitably raise issues of disputed law and facts. The Ombudsman's role should be to look at administrative failings.

15. We consider this would serve to slow down the process,

16. Will inevitably add additional costs on to local authorities.

Other issues

17. No comments

18. No comments

19. No comments

20. No comments

21. No comments

22. Do you have any comments on the following issues:

 jurisdiction – Yes potentially, but have no suggestions as to who they might be.

 recommendations and findings – We consider that bodies should retain the right to reject findings.

 protecting the title – No view.

 code of conduct complaints – Whilst acknowledging the drain of such complaints on the Ombudsman's resources we consider that it is vital that jurisdiction for these remains with the Ombudsman, as the Ombudsman plays an important role in enforcing the Code in an independent and dispassionate way, free from the danger of political influence that is inevitably present at local level. Local resolution Procedures have their place in dealing with low level member on member complaints but can only work if all members fully support them, and can be ineffective where the complaint has a party political dimension. County Councils do not have the resources to take responsibility for resolving town or community council member on member complaints.

23. No views

24. No views

I trust our comments are acceptable in this provided format.

CONSULTATION QUESTIONS

1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

There are limitations to the Act and it would seem reasonable to amend the act to reflect the changes in Society and to reflect the Putting Things Right regulations.

Own initiative investigations

2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on own initiative investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.

It is of course appropriate for the NHS to be open to external scrutiny to provide assurance to the public. However in order to respond fully to this question there would need to be further explanation of this power. I note that in the republic of Ireland between 2001 and 2010 only 5 such reviews have been undertaken. Clarification as to the triggers for these powers to be used is required. Furthermore there is need for careful consideration of the role of other regulatory/ inspectorate bodies such as Healthcare Inspectorate Wales and Community Health Councils and the need for sharing of intelligence to ensure that the most appropriate body undertakes a review.

3. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

Addressed in Point 2

4. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

The costs and benefits are difficult to quantify without full understanding of the powers sought.

ORAL COMPLAINTS

4. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.

It would seem reasonable to accept oral complaints, however there would need to be clear guidance on the verification of the information. Also clarity is required to reinforce that the process for investigation would remain unchanged. We also believe that consideration of an advocacy type of support/role for individuals to be assisted in formulating their concerns would be useful.

5. What other type/form of submission should be acceptable (e.g. email, website form, text messages)

Email, FAX, in person, telephone or via a web based programme with appropriate governance processes in place would be acceptable. In order to future proof the act the inclusion of social media should be considered even if it is not actioned at this time.

7. Do you have a view on the financial costs and benefits of this provision?

It would be assumed that increasing the methods by which one is able to raise a concern will increase the number of concerns raised. This would need to be considered from the perspective of Health Boards as well the Ombudsman's office.

COMPLAINTS HANDLING ACROSS PUBLIC SERVICES

8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.

The Health Boards in Wales follow the Putting Things Right regulations. They are reviewed by Welsh Risk Pool who adopts a formalised and consistent approach to monitoring the compliance with the regulations and importantly the implementation of lessons learned from Concerns. The model complaints policy is embedded within the legislative framework of the regulations and should continue to be monitored via the Welsh Risk pool. Furthermore the work within Welsh Government following the publication of the Evans report should be considered.

9. Do you have a view on the financial costs and benefits of this provision?

NA

OMBUDSMAN'S JURISDICTION

10. What are your general views on the Ombudsman's current jurisdiction?

There are some obvious limitations in so far as being able to accept concerns in any format.

11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?

It would not seem unreasonable; however would a private care provider be in accordance with the advice offered in an expert report. What would the sanctions be for failing to comply with a report and its recommendations and how would these be enforced?

12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)

This would need to be agreed with the private health care providers. Consideration as to whether they would prefer a case by case basis rather than a subscription however what powers would the Ombudsman hold should they choose not to engage in the process.

13. Do you have a view on the financial costs and benefits of this provision?

There would need to be a comprehensive plan agreed with private health care providers

LINKS WITH THE COURTS

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (I.e. this would give complainants the opportunity to decide which route is most appropriate for them.)

There is a fundamental point in this change if the Ombudsman wishes to consider cases that would previously have been pursued via litigation. In essence the Ombudsman is requesting a stay of limitation then all expert reports should be Bolam compatible. This in fact should be implemented and embedded in the revision to the Ombudsman Act. Care must be measured on what is reasonable and breaches in the duty of care should be clearly outlined in the report. If breaches are identified the aspect of causation should be considered.

15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?

It would need to be identified as to who funds any legal requests. There should also be consideration of the role of counsel advice to clarify a point of law rather than proceeding directly to the courts.

16. Do you have a view on the financial costs and benefits of this provision?

See point 15

OTHER ISSUES

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

With the new powers counsel advice could have been sought to clarify the law surrounding Continuing Health Care and the evidence required for retrospective payments to the benefit of the public and the NHS. This potentially could have facilitated earlier voluntary settlements.

18. Schedule 3 of the current 2005 Act provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

Private health care providers.

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

It would require an annual review.

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

With a likely increased demand upon the Health Boards to review the increased number of concerns without any additional resource. The Evans report has been clear in the recommendations that concerns teams need to have the necessary resources in terms of appropriate staffing levels. Whilst it is proposed that the Ombudsman's office would have additional resource of £270,000 per annum these proposed changes will have a domino effect upon NHS concerns teams and this should also be resourced appropriately.

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

Refer to point 20

22. Do you have any comments on the following issues:

- jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;

- recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;

As outlined in point 14 the expert reports need to be presented as reports that the clinicians would present in court because they are based upon the test of reasonableness.

There needs to be a transparent strategy to challenge the recommendation when they are unreasonable.

- **protecting the title - there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in**

jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman?

Yes that seems eminently reasonable and offers clarity to the public.

23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

Amendments to the Putting Things Right regulations, consideration of the Evans report.

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

Refer to point 14 and 22

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Committee Clerk
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Dear Sir/Madam

Standards Committee Response to Consultation Re Ombudsman's Powers

I refer to the inquiry being undertaken by the National Assembly for Wales' Finance Committee to consider extending the powers of the Public Services' Ombudsman for Wales.

The Vale of Glamorgan Council's Standards Committee has considered the five main areas that have been highlighted for potential legislative change, and the Committee's comments are listed below:

- **Own Initiative Powers**

The Standards Committee supported this proposal.

- **Oral Complaints**

The Standards Committee supported this proposal i.e. that the Ombudsman be permitted to consider oral complaints.

- **Complaints Handled Across Public Services**

The Standards Committee noted that the consultation document did not list the public services that would be encompassed and felt that it was outside of its remit to comment on this area of the consultation document.

- **The Ombudsman's Jurisdiction**

The Standards Committee felt that this topic fell outside of its remit.

- **Links With The Courts**

The Standards Committee felt that this topic fell outside of its remit.

Additionally, (with regard to the Ombudsman's preference to focus on the element of his work that deals with service users and service delivery, rather than local authority and Town and Community Council resolutions) the Standards Committee noted that the Council's Local Dispute Resolution Procedures were intended to deal with low level complaints within the Vale of Glamorgan Council. The system was not in place to deal with complaints involving Members of Town and Community Councils. Should extended powers be granted to Councils , there would be a requirement for the resulting increased workload to be adequately funded. In addition, there would be staffing implications.

Your sincerely

Ms. D. Marles
Monitoring Officer

Finance Committee Inquiry: Consideration of powers: Public Services Ombudsman for Wales

1. What are your views on the effectiveness of the current Public Services Ombudsman (Wales) Act 2005?

Ymateb i'r Ymgynghori

Ystyrir yn gyffredinol ei fod yn effeithiol. Dim sylwadau anffafriol gan ein cyfranwyr.

Consultation Response

Generally regarded as effective. No adverse views expressed by our contributors.

Own initiative investigations

2. Currently, the Ombudsman may only investigate a matter that is the subject of a complaint made to him/her. What are your views on 'own initiative' investigations powers, which would enable the Ombudsman to initiate his/her own investigations without having first received a complaint about an issue. Please explain your answer.

3. Do you have any concerns that own-initiative investigation powers could result in the Ombudsman's responsibilities overlapping with the responsibilities of other bodies? How could this be managed?

4. Do you have a view on the likely financial costs and benefits of the Ombudsman having own-initiative powers?

Ymateb i'r Ymgynghori

Mae hyn yn debyg i'r cysyniad o'r awdurdodaeth gynhenid sydd gan yr Ombwdsman o ran delio gyda chwynion yn ymwneud â'r Côd Ymddygiad ar gyfer Aelodau Etholedig. Fodd bynnag, yn y cyd-destun hwnnw, mae gan yr Ombwdsman awdurdodaeth unigryw. Nid felly yn yr achos hwn efallai ac mae'n creu sgôp ar gyfer dyblygu ac ansicrwydd ynghylch pwy ddylai fod yn ymchwilio i beth. Yn ein barn ni, mae hyn yn creu'r risg o ganlyniadau anghyson na fyddai'n fanteisiol i'r rheiny sy'n derbyn y gwasanaeth na'r rhai sy'n ei ddarparu. Wedi pwyso a mesur, byddem yn gwrthwynebu'r newid hwn yng nghyd-destun y strwythur cyfredol ar gyfer delio gyda chwynion ynghylch gwasanaeth.

Consultation Response

This is similar to the concept of the inherent jurisdiction which the Ombudsman has in relation to dealing with complaints relating to the Code of Conduct for Elected Members. However, in that context, the Ombudsman has an exclusive jurisdiction. That may not be the case here and creates scope for duplication and uncertainty as

to who would be looking into what. We think this creates a risk of contradictory outcomes that would not be to the benefit of either those receiving the service or those providing it. On balance we would oppose this change in the context of the current structure for dealing with service complaints.

Oral Complaints

5. At present, the Ombudsman can only accept complaints in writing. What are your views on the Ombudsman being able to accept complaints made orally? Please explain your answer.
6. What other type/form of submission should be acceptable (e.g. email, website form, text messages)
7. Do you have a view on the financial costs and benefits of this provision

Ymateb i'r Ymgynghori

Hyd yn oed os yw cwynion cychwynnol yn cael eu cyflwyno ar lafar, rydym o'r farn y dylid cael cofnod ysgrifenedig y cytunwyd arno er mwyn osgoi dryswch a chamddehongli a allai arwain at wastraffu adnoddau ymchwiliol. Yn ein barn ni, mae treulio amser ar y gwaith rhagarweiniol o sicrhau dealltwriaeth glir a chyffredin o'r materion dan sylw yn fuddiol iawn ac yn y pen draw, mae'n arbed amser a chostau.

Rydym yn cytuno, fodd bynnag, fod unrhyw gŵyn a gyflwynir "ar ffurf ysgrifenedig" yn dderbyniol gan gynnwys ebost, ffurflen ar wefan, negeseuon testun ac ati.

Consultation Response

Even if initial complaints are made orally we think there should be an agreed written record to avoid confusion and misinterpretation which might result in a waste of investigative resources. In our experience, time spent "front loading" to get a clear and common understanding of what the issues are, is time well spent and ultimately saves time and costs.

We agree, though, that any complaint "in written form" is acceptable including email, website form, text messages etc.

Complaints handling across public services

8. At present there is no consistency in the way public bodies deal with complaints. Adoption of the model complaints policy issued by the Welsh government is voluntary. What are your views on the Ombudsman preparing a model complaints policy which public bodies would be obliged to adopt. Please explain your answer.
9. Do you have a view on the financial costs and benefits of this provision?

Ymateb i'r Ymgynghori

Byddai'n well gennym ni fod wedi cael model statudol o'r cychwyn cyntaf, ond, erbyn hyn, mae 21 allan o'r 22 Awdurdod Lleol yng Nghymru wedi mabwysiadu Model yr Ombwdsman. Oherwydd lefel uchel iawn y gydymffurfiaeth, nid ydym yn gweld y deuai unrhyw fudd o'i wneud yn fandadol.

Consultation Response

We would have preferred a statutory model in the first place but, by now, 21 of the 22 Local Authorities in Wales have adopted the Ombudsman's Model. Given this very high level of compliance we cannot see the benefit of making it mandatory.

Ombudsman's jurisdiction

10. What are your general views on the Ombudsman's current jurisdiction?
11. At present the Ombudsman can investigate private health care that has been commissioned by the NHS. The Ombudsman would like the jurisdiction to be extended to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. This would enable the complaints process to follow the citizen rather than the sector. What are your views on extending the Ombudsman's jurisdiction in this way?
12. How do you think the investigation of private health care complaints should be funded? (Possibilities include a levy, charging on a case by case basis or no charge.)
13. Do you have a view on the financial costs and benefits of this provision?

Ymateb i'r Ymgynghori

Nid oes gennym unrhyw sylwadau ar y cynnig hwn.

Consultation Response

We have no views on this proposal.

Links with the courts

14. What are your views on the removal of the statutory bar to allow the Ombudsman to consider a case which has or had the possibility of recourse to a court, tribunal or other mechanism for review? (ie this would give complainants the opportunity to decide which route is most appropriate for them.)
15. What are your views on the Ombudsman being able to refer cases to the Courts for a determination on a point of law?
16. Do you have a view on the financial costs and benefits of this provision?

Ymateb i'r Ymgynghori

Nid ydym o blaid gwneud i ffwrdd â'r bar statudol. I bob pwrpas, byddai darpar ymgyfreithwyr yn cael y cyfle i ymarfer a mireinio eu hachos drwy broses yr Ombwdsman cyn ymgyfreithiad. Byddai'r broses yn mynd y tu draw i ddatgeliad cyn-gweithredu a byddai'n rhoi darpar ddiffinyddion dan anfantais oherwydd byddai'r Ombwdsman wedi gwneud canfyddiadau heb eu croesholi.

Mae'r hyn a gynigir yn debygol o achosi dyblygu, oedi, costau ychwanegol a byddai'n tanseilio'r rhagolygon ar gyfer cyflafareddu mewn rhai achosion priodol.

Consultation Response

We do not favour the removal of the statutory bar. Prospective litigants would effectively be given an opportunity to rehearse and refine their case through the Ombudsman's process prior to litigation. The process would go beyond pre-action disclosure and would place prospective defendants at a disadvantage as the Ombudsman would have made findings but without the benefit of cross-examination.

What is proposed is likely to cause duplication, delay, additional costs and to undermine the prospects for arbitration in some appropriate cases.

Other issues

17. Do you have any specific examples where the Ombudsman having the additional powers proposed could have been useful in securing a successful conclusion to an issue?

Ymateb i'r Ymgynghori

Nac Oes.

Consultation Response

No

18. Schedule 3 of the current 2005 Act, provides a list of authorities that are within the Ombudsman's jurisdiction to investigate complaints. Please provide details of any other bodies/organisations that should be included in this list?

Ymateb i'r Ymgynghori

Dim sylwadau.

Consultation Response

No comments.

19. If extended powers were given to the Ombudsman in a new Bill/Act, at what point should the impact of this legislation be evaluated?

Ymateb i'r Ymgynghori

Dim llai na 5 mlynedd wedi i'r ddeddfwriaeth ddod i rym.

Consultation Response

No less than 5 years after the legislation comes into force.

20. What unintended consequences could arise as a result of these provisions becoming legislation and what steps could be taken to deal with these consequences?

Ymateb i'r Ymgynghori

Gweler os gwelwch yn dda ein hymatebion i "ymchwiliadau ar ei liwt ei hun" (own initiative investigations), "cwynion ar lafar", "cysylltiadau gyda'r llysoedd" ac "argymhellion a chanfyddiadau"

Consultation Response

Please see our responses to "own initiative investigations", "oral complaints", "links with the courts" and "recommendations and findings"

21. What factors should be measured to determine the cost-benefit analysis of this legislation being brought forward?

Ymateb i'r Ymgynghori

Dim digon o wybodaeth wedi ei darparu i ni gynnig sylwadau.

Consultation Response

Insufficient information provided to enable comment.

22. Do you have any comments on the following issues:

- **jurisdiction – changes to the devolution settlement have led to new areas coming into jurisdiction over time, should consideration be given to other bodies being included in the Ombudsman's jurisdiction;**

  Ymateb i'r Ymgynghori

  Dylid ystyried creu un corff i ddelio gyda'r holl gwynion ynghylch gwasanaethau ar draws y sector cyhoeddus datganoledig yng Nghymru – dim yr Ombwdsman o angenrheidrwydd.

Consultation Response

Consideration should be given to creating a single body to deal with all service complaints across the devolved public sector in Wales. This need not be the Ombudsman.

- **recommendations and findings - should the recommendations of the Ombudsman to public bodies be binding. This would mean that bodies cannot decide to reject the findings;**

  Ymateb i'r Ymgynghori

  Na. Mae gwneud i ffwrdd â'r disgresiwn lleol yn creu'r risg o adolygiad barnwrol yn erbyn yr Ombwdsman.

  Consultation Response

  No. Removing the local discretion creates the risk of judicial review against the Ombudsman.

- **protecting the title - there has been a proliferation of schemes calling themselves ombudsmen, often without satisfying the key criteria of the concept such as independence from those in jurisdiction and being free to the complainant. Should anyone intending to use the title ombudsman gain approval from the Ombudsman;**

  Ymateb i'r Ymgynghori

  Rydym yn cytuno. Fel mae'n sefyll, mae'n dibrisio'r teitl ac yn creu risg i'r cyhoedd.

  Consultation Response

  Yes we agree. As it stands it devalues the currency and creates a risk for the public.

- **code of conduct complaints – the Ombudsman would prefer to focus on the element of his work that deals with service users and service delivery, rather than local authority and town and community councils' resolutions. Whilst a local resolution procedures exists and has been adopted by 22 local authorities, variance exists in practice.**

  Ymateb i'r Ymgynghori

  Cyfarfu Pwyllgor Safonau'r Cyngor i drafod y mater hwn ac mae o'r farn y dylai'r Côd Ymddygiad barhau i fod yn orfodol ac y dylai'r Ombwdsman barhau i weithredu ei bwerau i gynnal yr "hidliad cyntaf"; er mwyn atal cwynion

blinderus a rhai sy'n gwastraffu amser rhag llyncu adnoddau'r Ombwdsman a'r Cyngor.

Fodd bynnag,mae'r Pwyllgor Safonau'n cefnogi cynnig yr Ombwdsman i gyflwyno trydedd gangen i'w brawf trothwy; sef yr elfen budd y cyhoedd. Os yw'r Ombwdsman o'r farn nad yw cwyn yn cyrraedd y trothwy, yna dylid ei gwrthod waeth pwy yw'r achwynydd a waeth beth fo ei statws.

Byddid yn croesawu model o Brotocol ar gyfer Datrys Anghydfodau'n Lleol oherwydd mae trefniadau lleol yn amrywio. Mae'r isod ymysg y gwendidau y mae angen rhoi sylw iddynt:-

- y ffaith bod cydweithredu gyda chwyn a wneir dan y Protocol ar gyfer Datrys Anghydfodau'n Lleol yn gwbl wirfoddol sy'n golygu na fedrir gorfodi Aelod i gymryd rhan yn y broses os nad yw'n barod i wneud hynny.

- mae Protocolau ar gyfer Datrys Anghydfodau'n Lleol, yn yr amgylchiadau y maent yn berthnasol iddynt (sef cwynion mewnol ac agweddau cyfyngedig o'r Côd) yn creu gwrthdaro posibl ar gyfer aelodau'r Pwyllgor Safonau sydd wedi delio gyda'r mater dan y drefn leol, os bydd y mater wedyn yn cael ei uwch-gyfeirio i'r Pwyllgor Safonau yn dilyn cwyn i'r Ombwdsman.

Consultation Response

The Council's Standards Committee met to discuss this matter and is of the view that the Code of Conduct should remain compulsory, and that the Ombudsman should continue to exercise "first sift" powers; to avoid vexatious and time wasting complaints swallowing up Ombudsman and Council resources.

However, the Standards Committee does support the Ombudsman's proposal to introduce a third limb to his threshold test; namely the public interest element. If it is the view of the Ombudsman that a complaint does not reach the threshold then it should be rejected regardless of the identity or status of the complainant.

A model Local Resolution Protocol would be welcome as local arrangements vary. Among the weaknesses that need to be addressed are:-

- the fact that cooperation with a complaint made under the LRP is entirely voluntary and that if a Member is not prepared to participate then they cannot be compelled.

- LRPs, in the circumstances in which they apply (i.e. in-house complaints and limited aspects of the Code) create potential conflicts for members of the Standards Committee who have dealt with a local resolution, should the matter escalate to the Standards Committee following a complaint to the Ombudsman.

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23. Do you have any views on any aspects of future planned or proposed public sector reforms that would impact on the role of the Ombudsman?

Ymateb i'r Ymgynghori

Eglurder ynghylch swyddogaeth ac awdurdodaeth yr Ombwdsman o ran delio gyda gwasanaethau sydd wedi eu hallanoli i fodelau darparu eraill megis mentrau cymdeithasol neu ymddiriedolaethau cymunedol ac ati.

Consultation Response

Clarity on the role and jurisdiction of the Ombudsman in dealing with services outsourced to alternative delivery models like social enterprises or community trusts etc

24. Do you have any other issues or concerns about the current Act and are there any other areas that need reform or updating?

Ymateb i'r Ymgynghori

Na

Consultation Response

No

Grŵp Cartrefi Cymunedol Cymru

Community Housing Cymru Group

Response to the National Assembly for Wales Finance Committee's inquiry into the consideration of powers of the Public Services Ombudsman for Wales

Community Housing Cymru Group

1. About Us

The Community Housing Cymru Group (CHC Group) is the representative body for housing associations and community mutuals in Wales, which are all not-for profit organisations. Our members provide over 153,000 homes and related housing services across Wales. In 2011/12, our members directly employed 7,500 people and spent over £850m in the Welsh economy.[1] Our members work closely with local government, third sector organisations and the Welsh Government to provide a range of services in communities across Wales.

Our objectives are to:

- Be the leading voice of the social housing sector.

[1] Measuring the Economic Impact of Welsh Housing Associations, November 2012

- Promote the social housing sector in Wales.
- Promote the relief of financial hardship through the sector's provision of low cost social housing.
- Provide services, education, training, information, advice and support to members.
- Encourage and facilitate the provision, construction, improvement and management of low cost social housing by housing associations in Wales.

In 2010, CHC formed a group structure with Care & Repair Cymru and CREW Regeneration Wales in order to jointly champion not-for-profit housing, care and regeneration

Introduction

This paper is a response to the National Assembly for Wales Finance Committee's consultation on "an inquiry into the consideration of powers of the Public Services Ombudsman for Wales". CHC welcomes the opportunity to respond to the consultation and overall supports the proposals to give the Ombudsman wider jurisdiction and increased powers. However, any additional powers must be matched with the resources to maximise the effectiveness of these.

In responding to the inquiry we have considered in full the consultation questions and have noted key points below.

Key Issues

CHC believes that the Ombudsman is a critical service which supports social justice and drives improvement in public service delivery. However, the Public Service Ombudsman Act 2005 is 10 years old and does not reflect socio-economic and demographic changes and new models of service delivery.

To maximise the effectiveness of the Ombudsman service it is essential that the legislation is updated to reflect changes and trends that we know will continue well into the future.

We fully support and recognise the importance of the Ombudsman having the power to take oral complaints. Vulnerable people receiving public services may struggle with basic literacy skills and many may lack confidence in expressing their concerns in writing (this includes groups whose first language isn't English or Welsh). Some individuals with disabilities may also rely on others to communicate on their behalf and may not wish to burden them with making a complaint. Therefore by insisting that complaints are made in writing one unintended consequence of the current legislation is that the service isn't equally accessible to all and therefore discriminates against vulnerable groups.

We are aware and are concerned that a lack of confidence can prevent complaints being made. It takes a lot of effort to make a complaint and in many cases this is not done lightly especially if the individual is dependent on the provider for ongoing support. The impact of an ageing society could mean in future there are more individuals in vulnerable positions either unable or afraid to complain . For these reasons we agree that the Ombudsman should have investigations powers to initiate his/her own investigations.

CHC would like to see more support for providers where complainants have not followed due process and are acting unreasonably. We would also ask for more consistency and transparency in complaint handling by the investigators and a focus on proactive resolution rather than penalisation.

CHC is supportive of the two stage complaints process (followed by appeal) as best practice . Housing Associations generally have a two or three stage complaint process and most are aware or have adopted the model complaints policy issued by the Welsh Government. We agree that there should be a standard policy for complaints and encouragement given for all public service providers to adopt this, however, we would not want this as a legislative requirement as there maybe circumstances in which a two stage process is impractical. It is in the interests of both parties to come to a resolution quickly and limit the burden on organisations

under investigation. We believe a two stage process and the move to an electronic system will:

- help alleviate the burden on providers
- ensure more consistency in decisions, and
- improve communication and transparency.

An ageing population and current funding challenges for the NHS in Wales suggests that in future more people are likely to be accessing private health care and combinations of private and NHS care. Therefore to ensure the effectiveness of the service we believe it is necessary to extend the jurisdiction of the Ombudsman to enable him/her to investigate when a patient has received private healthcare (self-funded not commissioned by the NHS) in conjunction with public healthcare. We also believe/agree that the investigation of private health care complaints should be funded on a case by case basis.

This together with a focus on innovation and service integration focused on the needs of the service-user make it crucial that the Ombudsman has the power to investigate complaint handling across public services. Having said this information requests should only relate to any investigation in hand.

We also support the removal of the statutory bar to allow the Ombudsman to consider a case that has or had the possibility of recourse to a court, tribunal or other mechanism for review (this would give complainants the opportunity to decide which route is most appropriate for them and would hopefully minimise legal costs).

Conclusion

Complaints should drive service improvement and where complaints are not easily resolved with the service provider then the Ombudsman service allows for further examination of the issues and in doing so supports the wider aims and objectives of Welsh Government in ensuring social justice for all. The current legislation governing the Ombudsman's office is outdated and needs to reflect developments and best practice across the UK. Therefore CHC is supportive of the proposals.

Ymgynghoriad ar Ymchwiliad i Ystyried Pwerau Ombwdsmon Gwasanaethau Cyhoeddus Cymru - Gwelliannau i Ddeddf Ombwdsmon Gwasanaethau Cyhoeddus (Cymru) 2005

Mae'r ymatebion isod yn cyfateb i'r penawdau yn y "Papur" fel y'i gelwir yn y Llythyr Ymgynghori.

1: Cyflwyniad:

Mae'n hollbwysig bod arolwg yn digwydd sy'n seiliedig ar brofiadau'r deng mlynedd ddiwethaf er mwyn sicrhau gwasanaeth effeithlon ar gyfer y dyfodol.

2: Pum Maes ar gyfer Newid

2.1: Ymchwiliadau o ‘mhen a mhastwn fy hun:

- Credaf y dylai'r Ombwdsmon gael y pwer i ymchwilio i achos heb gwyn benodol pan fo galw amlwg am hynny.

- Os oes cwynion niferus ac amrywiol yn dod i law ynglyn â chorff neu unigolyn cyhoeddus, fe ddylai'r Ombwdsmon feddu ar yr hawl i agor a chynnal ymchwiliad lletach i'r rhesymau tu ôl i'r cwynion niferus. Mae'r Ombwdsmon mewn sefyllfa i weld darlun llawer ehangach na'r unigolion sy'n cyflwyno cwynion unigol, ac os oes patrwm o gwynion yn datblygu, credaf bod dyletswydd ar yr Ombwdsmon i ymchwilio ymhellach ar ein rhan, ac i ddyfarnu er mwyn dileu'r achos am rhagor o gwynion tebyg. Yn y pen draw fe all hyn arbed amser ac arian cyhoeddus.

- Mae'n wir bod problemau systemig o fewn rhai o'n sefydliadau cyhoeddus. Os oes tystiolaeth bod corff neu unigolyn cyhoeddus yn methu'n gyson yn ei ddyletswydd fe ddylai'r Ombwdsmon feddu ar yr hawl i agor a chynnal ymchwiliad lletach i'r rhesymau tu ôl i'r methiannau cyson hyn. Mae'r oes wedi newid, a dydy rhai o safonnau ymddygiad personau cyhoeddus neu ddarpariaeth gwasanaeth gyhoeddus ddim yn dderbyniol erbyn hyn. Er hyn, mae rhai cyrff, sefydliadau ac unigolion cyhoeddus yn dal i gredu nad ydynt yn atebol i'r cyhoedd. Ni allwn fod yn saff bob amser bod unigolion o'r gymuned yn barod i wneud cwyn swyddogol, felly, mewn ambell i sefyllfa, mae hawl yr Ombwdsmon i gychwyn cwyn ar ei liwt ei hun yn hanfodol.

- Os ydy swyddfa OGCC yn annog pobl i wneud cwyn pan fo'n briodol (neu'n fandat mewn corff cyhoeddus), mae'n rhaid felly i'r Ombwdsmon allu derbyn cwyn gan gorff. Os nad ydy hyn yn bosib, mae'n rhaid i'r Ombwdsmon gael yr hawl i wneud cwyn "ar ei liwt ei hunan" - ar ran y cyhoedd y mae'r corff yn eu cynrychioli - heb bod unigolyn yn gorfod cyflwyno'r gwyn ar ran y corff. Mae canlyniadau gwneud cwyn yn erbyn

unigolyn o fewn cymuned fechan yn gallu bod yn annifyr, a gall swyddfa OGCC ddim disgwyl i unigolion sy'n gwasanaethu eu cymuned ar y rheng isaf herio pwerau llawer uwch heb gefnogaeth. Mae cyfrinachedd y broses (sy'n hollol gywir) yn rhwystro unigolyn rhag datgan bod y gwyn, mewn gwirionedd, yn enw corff cyhoeddus. O ganlyniad, gall y gymuned ddim gwybod bod cwyn wedi ei chyflwyno ar ei rhan. Mae'n hollol angenrheidiol felly bod swyddfa OGCC naill ai yn gallu diwygio'r rheolau i ganiatau bod corff yn gallu cyflwyno cwyn yn erbyn corff neu unigolyn arall, neu bod yr Ombwdsmon yn gallu cyflwyno'r gwyn ar ei liwt ei hunan ar ran corff.

- Mae'n hanfodol bod rheolaeth dros bwerau OGCC. Fel unigolyn, rydwi'n credu'n llwyr yn annibyniaeth ymchwiliad a dyfarniad swyddfa OGCC, ond mae'n rhaid wrth demplat rheolaeth hollol ddibynadwy a thryloyw ar unrhyw bwerau ychwanegol i warchod yr annibyniaeth hwn a chynnal ffydd y cyhoedd yn y system.

- Mewn hinsawdd lle bo hawl ar bawb i gael mynediad i wybodaeth a fu'n gyfrinachol yn yr oes o'r blaen (sy'n hollol gywir), mae'n llawer anoddach i unigolyn gyflwyno cwyn heb ofni ymateb chwyrn oddiwrth targed y cwyn. Os oes ymarfer drwg gan unrhyw unigolyn neu sefydliad cyhoeddus yn dod i sylw'r Ombwdsmon mae'n ddyletswydd arno/arni i ymchwilio i'r mater er lles y mwyafrif tawel.

- Credaf hefyd y dylai'r Ombwdsmon feddu ar y hawl i ymchwilio pan fo nifer o gyrff rheoli/beirniadu wedi dod i'r casgliad bod cam-ddefnyddio grym wedi digwydd o fewn sefydliad cyhoeddus ond lle bo'r sefydliad hwnnw wedi dewis anwybyddu'r rheoliad/feirniadaeth a bwrw ymlaen yn erbyn lles y cyhoedd. Os nad yw hyn yn achos a ellir ei ddatrys mewn llys, neu os nad oes gorchymyn statudol i weithredu argymhellion y corff rheoli/beirniadu, mae angen i'r Ombwdsmon ddyfarnu ar ran y cyhoedd.

- Mae tryloywder yn hollol hanfodol yn y dyddiau sydd ohoni. Yr unig lwybr sydd gennym fel unigolion i sicrhau tryloywder di-duedd effeithlon yw trwy wasanaeth OGCC. Credaf bod ehangu pwerau'r Ombwdsmon yn y maes hwn yn gwarchod ein buddiannau ni.

2.2: Cwynion Llafar

- Mae'n rhaid diwygio'r rheolau er mwyn caniatau cwynion ar lafar.

- Does dim angen dweud bod y cyfran o'r cyhoedd sydd ddim yn meddu ar sgiliau darllen ac ysgrifennu yn methu cael mynediad i'r broses. Yn ogystal, er bod ffurflen cyflwyno cwyn swyddfa OGCC yn weddol syml a di-drafferth, fe fydd rhai yn ein cymunedau yn ofni'r broses, neu â diffyg hyder yn eu sgiliau i gyfathrebu eu cwyn yn effeithiol ar bapur.

- Os nad ydy unigolyn yn meddu ar sgiliau cyfrifiadurol mae'n eithaf tebygol ei fod wedi gorfod holi a chymryd cyngor ar sut i wneud cwyn, ac i bwy, gan gorff megis y CAB ac eraill. Mae'r broses o gyflawni torraith o waith papur yn gallu dileu'r chwant am wneud y cwyn, ond pe bai cyfle i unigolyn ymweld â swyddog, neu dderbyn ymweliad gan swyddog, a chyflwyno cwyn ar lafar, fe fyddai hynny'n llawer mwy cyfforddus ac yn sicrhau bod cwyn dilys yn cael ei hystyried.

- Mae'n rhaid rhoi cyfle cyfartal i aelodau mwyaf bregus ein cymunedau i ddatgan eu pryderon pan fo anghyfiawnder yn y fantol.

2.3: Ymdrin â Chwynion Ar Draws Gwasanaethau Cyhoeddus

- Mae'n rhaid i rywun wisgo'r fantell hon.

- Ar hyn o bryd mae gan gyrff cyhoeddus brosesau i ddelio gyda chwynion a gyflwynir gan aelodau o'r cyhoedd, ond, os nad ydy'r prosesau hynny yn gweithio, nac yn cael eu gweld yn gweithio yn llygad y cyhoedd, mae'n anodd iawn dod o hyd i lwybr i ymchwilio ymhellach heb fynd ag achos i'r llys. Os nad oes tor-cyfraith wedi digwydd dydy'r llwybr hwn ddim ar gael ychwaith.

- Dydy prosesau ein hawdurdodau lleol ddim bob amser yn gallu ymateb yn briodol i gwyn. Weithiau bydd gwrthdrawiadau o fewn yr awdurdod sy'n golygu bod yr awdurdod hwnnw'n methu ymateb yn deg.

- Enghraifft o hyn yw pan fo cwyn yn dod i sylw adran gyfreithiol cyngor sir, yn erbyn cynghorydd neu aelod o'r staff, gan gyngor tref neu gymuned. Mewn achos fel hyn mae cyfansoddiad y cyngor sir yn datgan bod dyletswydd ar adran gyfreithiol y cyngor sir i ddarparu cyngor cyfreithiol i'r aelod/staff yn y cyngor sir ei hunan ac hefyd i'r cyngor tref/cymuned sydd wedi cyflwyno'r gwyn. Os nad ydy'r adran gyfreithiol sy'n gwasanaethu'r gwahanol haenau o gynghorau lleol yn gweithredu'n ddi-duedd, a chynrychioli pob cyngor fel a nodir yn eu cyfansoddiad, mae un o'r cynghorau'n colli mynediad at gyngor cyfreithiol rhad.

2.4: Awdurdodaeth yr Ombwdsmon (i gynnwys gwasanaethau iechyd preifat).

- Does gen i ddim profiad o'r anhawsterau a all godi oherwydd cymysgu darpariaeth GIG a'r sector breifat. Fodd bynnag, rydwi'n cytuno gyda'r cynigion yn y papur ar yr wyneb. Wn i ddim faint o hawl ddylai'r Ombwdsmon gael i ddyfarnu dros y sector breifat, ond tra bo system yn bod lle caniateir cymysgu'r ddwy ddarpariaeth mae'n rhaid cael trefn o gwyno sy'n cynnwys pob cyfrannwr i'r broses o drin claf sy'n defnyddio'r ddau.

2.5: Cysylltiadau â'r Llysoedd

- Mae'n rhaid cael gwared ar y bar statudol sy'n gwrthod yr hawl i'r Ombwdsmon i ystyried achos lle mae posibilrwydd y bydd yn cael ei adolygu gan lys, tribiwnlys neu broses arall.

- Pan fo unigolyn yn cyflwyno cwyn am weithred yn erbyn unigolyn neu gorff fe ddylai'r gwyn honno gael ei hystyried dim ond yng nghyd-destun y weithred honedig. Mae gan pob unigolyn yr hawl i gyflwyno cwyn am ymddygiad rhywun neu rywrai cyhoeddus sy'n gweithredu ar ei ran, ac mae côd ymddygiad unigolion a chyrff cyhoeddus yn datgan yn glir beth yw'r safonnau a ddisgwylir.

- Os ydy unigolyn neu gorff yn gweithredu yn groes i'r gyfraith, mae hynny'n fater i'r llys, ond os ydy'r weithred yn mynd yn groes i'r côd ymddygiad fe ddylai'r achos hwnnw gael ei ystyried yn hollol ar wahan gan swyddfa OGCC a thu allan i gyd-destun unrhyw achos llys perthnasol.

- Mae'r llys yn dyfarnu ar yn ôl cyfraith gwlad - mae'r Ombwdsmon yn dyfarnu ar faterion sydd efallai'n gyfreithlon ond yn anghywir. Mae'r gwahaniaeth yma'n hollbwysig.

- Os oes achos difrifol yn codi lle bo ymddygiad unigolyn neu gorff yn arwain at achos llys, ni ddylai'r Ombwdsmon orfod aros am ddyfarniad llys cyn gweithredu ar gwyn o gam-ymddwyn.

- Gall yr achwynwr ddilyn un neu'r ddau lwybr - llys a/neu Ombwdsmon. Dydy'r llys ddim yn aros am ddyfarniad gan yr Ombwdsmon, a dylai'r Ombwdsmon ddim gorfod aros am ddyfarniad gan y llys - mae eu criteria dyfarnu yn hollol wahanol.

3: Cost Newid
Dim sylw penodol. Dydy'r costau fel y'i nodir ddim yn uchel o ystyried y gwelliannau arfaethedig i'r gwasanaeth .

4: Y Ddadl Dros Newid
Mae'r sylwadau uchod yn cadarnhau'r ddadl dros newid.

Islaw nodir ymatebion i'r penawdau a welir ar dudalen y wefan -
Yn Ogystal - caiff y Pwyllgor ystyried y canlynol hefyd:

Awdurdodaeth:
- Dim barn bendant ar hyn o bryd.

Argymhellion a Chanfyddiadau:

- Fe ddylai argymhellion a chanfyddiadau'r Ombwdsmon i gyrff cyhoeddus fod yn orfodol. Ni ddylai cyrff cyhoeddus fod â'r hawl i benderfynu gwrthod y canfyddiadau.
- Eto, lle bo tryloywder yn hanfodol, rhaid i'r cyhoedd weld bod gweithred ddrwg yn arwain at gosb a/neu gywiro o ryw fath. Heb hyn, does dim diben cyflwyno cwyn yn y lle cyntaf.
- Mae'r cyhoedd yn gyffredinol yn credu nad oes pwrpas cyflwyno cwyn gan nad oes canlyniad i'w weld. Pe bai dyfarniad yr Ombwdsmon yn golygu bod cosb a/neu gywiro'r cam yn digwydd, yna byddai unigolion yn fwy parod i gyflwyno cwyn, ac, o ganlyniad, fe fyddai'r unigolion/cyrff cyhoeddus yn ymddwyn yn fwy cywir.
- Fe ddylai hyn, yn y pen draw, arwain at ymddygiad gwell a dileu'r achos am gwyno. Hyn ddylai fod yn ddiben y broses.

Amddiffyn y Teitl:

- Fe wyddom bod "ombwdsmon" yn enw ar gyfer amryw wasanaethau sy'n amddiffyn hawliau'r unigolyn. Er bod y gwasanaethau hyn yn amrywiol, ni ddylai'r teitl gael ei ddefnyddio heb yr hawl statudol i weithredu.
- Heb yr hawl statudol i weithredu dyfarniad dydy'r teitl yn werth ddim.

Côd Ymddygiad Cwynion:

- Fe ddylai'r Ombwdsmon ganolbwyntio ar ar yr elfen o'i waith sy'n ymdrin â defnyddwyr gwasanaethau a safonnau darparu gwasanaethau, yn hytrach na phenderfyniadau awdurdodau lleol a chynghorau tref a chymuned.
- Cwyn i'r Ombwdsmon yw'r unig lwybr sydd ar gael i ddefnyddwyr gwasanaethau gwyno am ddarparwyr gwasanaethau, tra bo amrywiol lwybrau i'w dilyn wrth wrthwynebu penderfyniadau awdurdodau lleol a chynghorau tref a chymuned.
- Mae penderfyniadau cyrff cyhoeddus yn agored i herion trwy'r llysoedd, ac er bod hynny'n geuedig i fwyafrif y cyhoedd oherwydd y gost, mae'r hawl hwnnw yn bodoli.
- Yr Ombwdsmon yw'r unig lwybr lle bo ymchwilio i'r ffordd y gwneir penderfyniad yn gallu digwydd. Mae hwn yn hollol hanfodol. Heb hwn, does gan yr unigolyn, na'r cyhoedd, unrhyw lais i sicrhau cyfiawnder.

Agweddau Eraill:

- Mae gen i enghreifftiau penodol lle gallai rhoi'r pwerau ychwanegol i'r Ombwdsmon fod wedi bod yn ddefnyddiol. Ni allaf ymhelaethu gan bod cwyn cyfredol gen i dan ymchwiliad gan OGCC. Buaswn yn falch o gyflwyno enghreifftiau dan amodau cyfrinachol.
- Dylid gwerthuso unrhyw bwerau ychwanegol o fewn pum mlynedd. Dylid gwerthuso'r gost yn erbyn nifer y cwynion, a'r arbedion arian cyhoeddus a ddaw o ganlyniad i weithredu mwy effeithlon gan ein hawdurdodau lleol.

PWYSIG: UN SYLW YCHWANEGOL:
Er mwyn sicrhau cyfrinachedd, ni ddylai stamp PUBLIC SERVICES OMBUDSMAN FOR WALES ymddangos ar flaen bob amlen o gyfathrebiaeth sy'n dod at achwynwr drwy'r post. Mae'n ddigon anodd cadw achos yn dawel heb eich bod chi'n cyhoeddi i'r postmon, a phawb arall sy'n byw yn y tŷ, bod llythyr wedi dod o'ch swyddfa!