Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Cyllid ar Adolygiad o weithrediadau, prosesau ac ymchwiliadau Ombwdsmon Gwasanaethau Cyhoeddus Cymru.

This response was submitted to the Finance Committee consultation on the Review into the operations, processes and investigations carried out by the Public Services Ombudsman for Wales.

PPSOWA1: Ymateb gan: Ombwdsmon Gwasanaethau Cyhoeddus Cymru | Response from: Public Services Ombudsman for Wales

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Consultation response

Consultation title : Post-legislative review of the Public Services Ombudsman (Wales) Act 2019

Organisation name: Senedd Cymru: the Finance Committee

Submitted: 28 March 2025

As Public Services Ombudsman for Wales (PSOW), we have three main roles:

- We investigate complaints about public services.
- We consider complaints about councillors breaching the Code of Conduct.
- We drive systemic improvement of public services and standards of conduct in local government in Wales.

We are independent, impartial, fair and open to all who need us. Our service is free of charge.

Foreword

Thank you for the opportunity to respond to this inquiry.

The Public Services Ombudsman (Wales) Act 2019 was a landmark piece of legislation, designed to strengthen and futureproof our office with a suite of new powers—powers unmatched by any other ombudsman in the UK, at that time. The reform was intended to make our office more proactive in identifying and investigating issues in public services, more impactful in shaping complaints handling across the Welsh public sector and more accessible to those who might struggle to make their voices heard.

With these new powers came great responsibility. While the Senedd (then the National Assembly for Wales) was supportive of the reform proposals, it was clear that the new powers must add value for the people of Wales and the public services they rely on. The requirement for a five-year review was built into the legislation and, from the outset, we recognised the importance of demonstrating the impact of the reform.

At the time of the launch of the 2019 Act, no one could have foreseen the outbreak of the COVID-19 pandemic and its profound consequences for public services in Wales and beyond. Our ability to utilise the new powers was inevitably shaped by these challenges. This included the difficult decision to delay our first 'own initiative' investigation and the roll-out of our model complaints policy. We also experienced issues in embedding our new service to accept complaints other than in writing. Yet, despite these unprecedented circumstances, we are confident that we have realised the promise of the 2019 Act.

We know that no one organisation is responsible for delivering justice and improving services for the people of Wales. Identifying, quantifying and attributing impact is never a straightforward process and many factors come together to drive change. We also know that there is always room for improvement in how we work and we are open about ways in which our new powers could be more impactful.

Nevertheless, we believe this submission provides rich evidence of how our proactive powers have benefited service users, the Welsh public and service providers, alike. The 2019 Act has strengthened our ability to protect and promote fairness in public services. Supported by the proactive powers entrusted to us, our office remains at the forefront of best ombudsman practice in the UK and internationally.

This is legislation that Wales can be proud of.

Summary

Since 2019, we have used our proactive powers broadly to deliver improvements for the people of Wales and to remove barriers for disadvantaged and vulnerable groups. Our use of these powers coincides with the rise of public confidence in our office.

To date, we have helped over 700 people to complain to us other than in writing, including using British Sign Language. There is evidence that this service is used commonly by disabled people, although it also removes barriers for other groups.

We have closed 10 extended investigations. Testimonies from complainants highlight the human impact of this power, as we are able to bring injustice to light without asking vulnerable people to repeat lengthy complaints processes.

We undertook 2 wider own initiative investigations. Both investigations looked into issues affecting vulnerable and disadvantaged groups: homeless people and unpaid carers. Our first investigation led to some service improvements, though further action is still needed. Evidence from third sector organisations pointed to appreciation of these investigations and general support for our recommendations. Evidence from organisations within our jurisdiction showed that, on the whole, our own initiative investigations were seen as an appropriate and constructive power, particularly in areas lacking regulatory oversight, by providing an external eye on public interest issues.

We have not yet had to use the power to investigate private healthcare, as we have not received any complaints that have met the requirements set out by the Act which reached our threshold for investigation. However, we firmly believe that the rationale for the Ombudsman to retain this power remains as strong as ever.

To date, 54 public service providers across Wales operate our model complaints policy. We regularly publish data on how local councils and Health Boards handle complaints. We have provided more than 550 training sessions to over 10,000 people. The majority of organisations under our complaints standards agree that our training and data monitoring has had a positive impact on their processes. There is also evidence that, since 2020, a higher proportion of the Welsh public finds complaints processes easier to navigate and is happier with how their complaints have been resolved.

In our view, our use of these powers has met the policy objectives of the 2019 Act and delivered value for money for the Welsh public.

However, there are ways in which the impact of our proactive powers could be improved and our broader ability to deliver justice strengthened.

As an office, we can:

- improve awareness of our power to accept complaints other than in writing
- strengthen third sector engagement with our own initiative work.

However, further improvements could only be delivered by the Senedd. These include:

- removing the statutory bar which prevents us from considering a complaint when it could be considered by the courts
- bringing into our jurisdiction complaints about schools and governing body decisions in Wales
- streamlining the process required to launch a wider own initiative investigation
- enabling us to issue sector-wide statutory recommendations, following a wider own initiative investigation.

Terminology

Throughout this paper, we will refer to the Public Services Ombudsman (Wales) Act 2019 as 'the 2019 Act'. We will also use the term 'proactive powers'. This is how we refer to the new powers given to us by the Senedd under the 2019 Act – the power to:

- accept complaints other than in writing
- undertake investigations on our own initiative – so we can investigate even when we have not received a complaint
- act as the Complaints Standards Authority (CSA) for Wales – working with public service providers to improve how they handle complaints
- consider, in quite limited circumstances, private health care, when alleged

maladministration or failures in NHS care cannot be investigated effectively or completely without also investigating any private health care provision.

Data and research informing this submission

Throughout this submission, we will be referring to the following data and research:

Our casework and equality data

All casework and equality related data that we refer to is accurate as at 4 March 2025.

Complaints standards data

The submission refers to complaints standards data between 2021/22 and September 2024.

Data on our financial performance

All information on direct costs is reported up to 31 March 2024 (to reflect and match the 5-year period of financial estimates set out in the Regulatory Impact Assessment).

Wales Omnibus Survey

Wales Omnibus Survey is a national survey undertaken annually by Beaufort Research. The sample is designed to be representative of the adult population resident in Wales aged 16 and over. We regularly commission a segment in this survey to gather information on general experiences of complaining in the public sector, and awareness and perceptions of our office.

Independent report on views from Third Sector Organisations in Wales on the Public Services Ombudsman for Wales Own Initiative Investigations 2021-2025

This independent project was undertaken by Ruth Marks CBE (former Chief Executive of WCVA and Older People's Commissioner for Wales) between February and March 2025. We attach at Appendix A the report on this research to this submission.

Telephone survey of complaints officers at local councils, Health Boards and Housing Associations

We commissioned this survey to gather views on the officers' experience of the most recent contact with us and general perceptions of the quality of our work. The survey was conducted in February and March 2025.

Stakeholder Research

We commissioned eight in-depth personal interviews with representatives of local councils, Health Boards and Housing Associations. All stakeholders who took part were Chief Executives or were part of the senior leadership team within the organisation. The depth interviews lasted for around thirty minutes and were carried out online over Microsoft Teams between the 24th February and 20th March 2025. We attach at Appendix B the report on this research to this submission.

1. The effectiveness of our powers and public confidence in our office

The operation and effectiveness of the 2019 Act to date and whether it has enhanced the role of, and increased public confidence in, the Public Services Ombudsman for Wales (PSOW).

Our general work

The review considers the operation and effectiveness of the 2019 Act to date. Although it looks mainly at how we have used the 'proactive powers', it is important to firstly say a few words about our complaints service. This remains the core of our work, the 'bread and butter' of our service, and the main route through which we help complainants and support public services to improve.

Since April 2019, we have handled over 15,000 complaints about public services. We delivered justice for just over 2,900 people, either by resolving their complaint early or by upholding their complaint after investigation.

We issued over 7,600 recommendations to public service providers. Consistently, between 20% and 30% of these recommendations have been about longer term improvements – for example, through training or feedback for staff, reviews of current practice, or recommending that a procedure should change. We have also issued 38

public interest reports and 5 thematic reports, highlighting lessons for systemic improvement across the public sector in Wales.

Between 2019/20 and 2023/24, our caseload has increased by 37%. The ombudsman service has never been more needed and never has it been more important that we do all we can to support the systemic improvement of public services.

Our annual reports, which include full details of our performance, are available on our website.

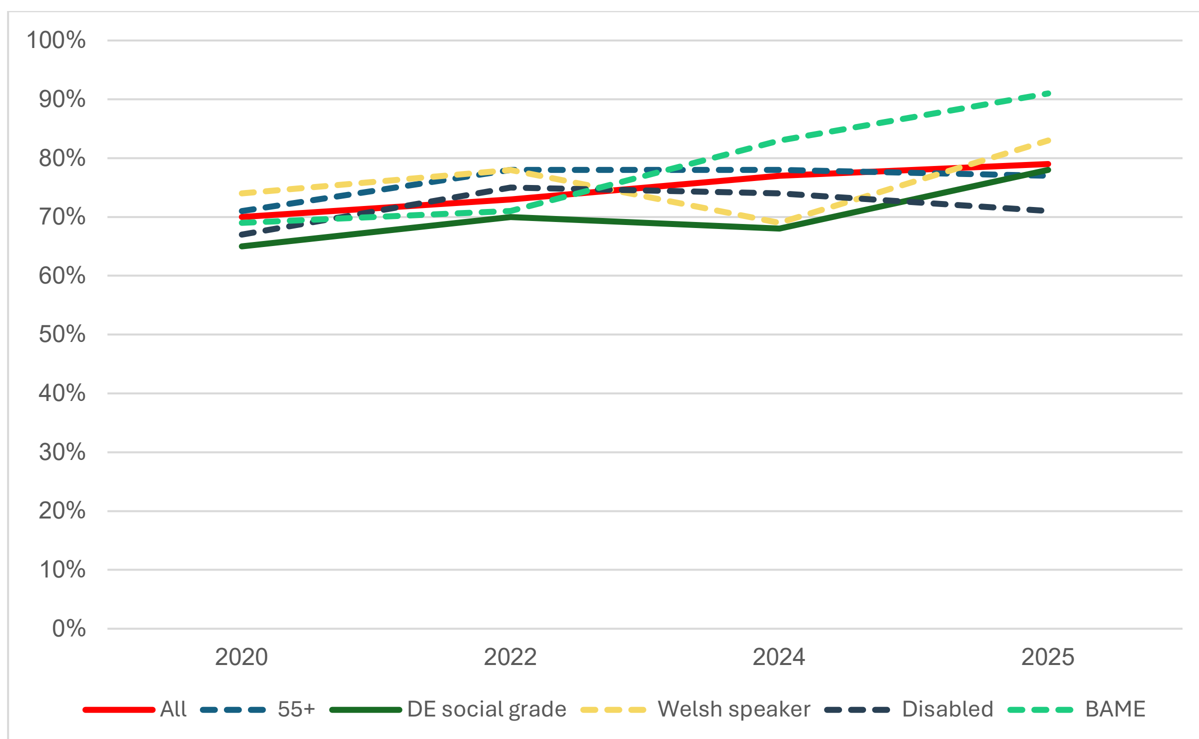
Perceptions of our integrity and impact

While we talk in detail later in this paper about how we have used each of our proactive powers, we want to focus first on the general perceptions of our integrity and impact.

We regularly check the level of awareness of our office and confidence in our service. In 2012, only 35% of people surveyed recognised our name, when asked. In 2025, the national awareness of the office stood at 48%.

The same research has suggested that confidence in our office remains high. In 2025, 79% of respondents said that they had confidence in us – the highest proportion on record and 9 percentage points higher than in 2020. Positively, this assessment was higher than average for almost all potentially vulnerable groups of complainants:

Figure 1: Proportion of people in Wales who said they had confidence in our work



It is also important to know how our impact is assessed by public service providers. Of the complaints officers that responded to our survey this year:

- 90% said that we are impartial (with none disagreeing)
- 83% said that our findings positively influence their organisation
- 90% said that our findings contribute to improving public services in Wales.

In addition, senior respondents to our stakeholder research indicated, overall, a high level of trust in our decision making and recommendations, though implementing our recommendations promptly was noted as one of the main challenges.

> *"As an organisation we take learning very seriously. So we will embed the Ombudsman learning into our normal learning processes… I think the learning and improvement is probably the most important part. It can be very useful because it's almost a third eye, isn't it? The Ombudsman is very good at seeing it from the complainant's lens and sometimes helps you to think a little bit differently about the learning and the recommendations." (a Health Board representative)"*

> *"I think it's fair to say it still carries a fair amount of gravitas. You don't want to be found wanting by the Ombudsman. I think it's got a certain amount of added*

weight to it as opposed to perhaps by the inspectorate or another agency." (a local council representative)

Our proactive powers provide additional mechanisms through which we are able to highlight when things have gone wrong with public services and drive improvement. We consider that our use of the powers since the Act took effect, as evidenced in this submission, demonstrates how the proactive powers have enhanced our role and contributed to increasing levels of public confidence in the work of the office.

Areas for improvement

The Statutory Bar - Alternative Legal Remedy

When we first made the case for change to our legislation back in 2015, we highlighted that the Law Commission had reviewed the legislation governing public services ombudsmen in England and Wales, in its report of July 2011. One of the recommendations it made was to remove the statutory bar which prevents us from considering a complaint when the case could be considered by the courts. We have discretion to set this restriction aside in certain circumstances, on a case by case basis, under section 13(2) of the Act. However, the Law Commission recommended that this bar should be set aside entirely, so that complainants could choose which is the more appropriate route for them and so that ombudsmen have broad general discretion to accept complaints.

The existence of the statutory bar in the Act means that, even when we decide that a complaint has merit and meets our threshold for investigation, we must decline to accept a case for investigation if it appears that the complainant has, or had, a legal remedy available to them. We believe that removing this bar, in line with the Law Commission's recommendation, would further strengthen public confidence in our office and lead to greater access to justice for citizens in Wales.

Education – school complaints

We have a very limited role in relation to complaints about education matters. Our remit is mainly limited to school admission and exclusion appeal decisions.

Although the Office of the Independent Adjudicator considers complaints about further and higher education in Wales, there is no equivalent access to an independent and impartial complaints handling body in relation to complaints about schools and

governing body decisions in Wales. Both the Northern Ireland Public Services Ombudsman and the Scottish Public Services Ombudsman consider complaints about schools.

Of all devolved public services in Wales, it is only schools which fall outside our (or any other independent complaint handling body's) remit. In our view, this represents a significant gap in how parents and pupils can access administrative justice in Wales, beyond local complaint handling procedures. In addition, we are currently unable to promote better complaint handling practice in school complaints processes using our complaints standards powers.

2. Complaints other than in writing

The practical application of the process by which oral complaints are accepted by PSOW and whether the ability for PSOW to specify requirements for making a complaint in guidance has improved social justice and equal opportunities for citizens of Wales.

Background

Prior to the 2019 Act, we could only accept complaints in writing. Although we had discretion to accept a complaint in another form, if appropriate, we had to consider this on a case by case basis. However, when making our case for reform, we pointed out that this requirement can create barriers for many groups that could struggle to read or write in Welsh or English. In 2015, we highlighted that 13% of Welsh adults had not reached Level 1 of basic literacy skills, which meant that at least 1 in 8 adults could struggle with written complaints processes.

How we have used this power to date

We have created guidance on how to submit complaints to us about service providers. This guidance explains that it is possible to complain to us by telephone. See the guidance here. In addition, we also have a more detailed factsheet explaining our process for taking these complaints. See the factsheet here.

We tend to take complaints other than in writing during a dedicated appointment. This gives the caller and our staff enough time (30-60 minutes) to discuss issues and record

all the necessary information. We also do this to make sure our main telephone line stays open to the public.

However, we can also take a complaint other than in writing “on the spot”, as long as we can make sure that we can look into the organisation complained about and that the complaint is duly in line with the requirements in the Act. We tend to take a complaint “on the spot” if a caller is in some distress or if the matter and circumstances appear extremely urgent.

Initially, the numbers of people using this service were low. In 2020/21, we took 63 oral complaints, against a target of 120. A significant factor was that, for almost half of that year, during the early period of the COVID-19 Pandemic, we could not record oral complaints in the normal way, as our staff had to work from home without access to appropriate telephony. We were able to take a small number of oral complaints, when staff could attend the office to do so, in the summer of 2020.

We then procured, installed and configured new telephony software and hardware to enable staff to take oral complaints from their homes and the numbers of people submitting complaints to us other than in writing began to increase. To date, we have helped over 700 people to complain in this way.

Figure 2: Complaints other than in writing in numbers

2019/20	2020/21	2021/22	2022/23	2023/24	2024/25 to date
46	63	221	160	103	139

Our impact

We asked for this power to make sure that people do not face any barriers when using our service. The power has contributed to the widespread accessibility of our service and reflects public expectations.

Analysis of our casework clearly shows that this service supports disabled people. Between April 2019 and March 2025, 39% of people who complained to us about public

services[1] said they had a health problem or disability that affected their daily life. However, among the people who submitted complaints other than in writing, this proportion raised to 53%.

Below, we include a few examples of complaints submitted to us other than in writing, illustrating the wide range of subject matters and personal needs of the complainants.

Complaint reference 202302069

A person who had difficulty with written words and needed information in large print told us that a local council did not meet his needs and restricted his contact with its offices. We found that, although the council may have been reasonable to restrict contact, it should have communicated with the complainant using large print. The council agreed to apologise to the complainant and ensure that all departments write to him in large print in the future.

Complaint reference 202100256

A caller who could not read or write complained to us by telephone about complex social services and housing matters. After we looked at all the evidence, we decided that we could not take the complaint forward - some issues related to events from over 10 years previously and others had been taken through a formal court process. However, we could help the caller to find an advocate to possibly assist in any future dealings with us and the organisations complained about.

Complaint references 202105382 & 202303340

Ms A complained about an ill-fitting dental brace which was causing her severe headaches. We took her complaint through a BSL signer and via video recording. Because Ms A had consulted a private dentist and her treatment was not provided by the NHS at all, we were not legally able to look further into her complaint. We explained our decision to her in a Zoom meeting (in addition to sending a written decision letter) and we advised her how to pursue her complaint with the private practitioner. The same person subsequently complained to us again, 18 months later, about an issue related to her social landlord. This shows confidence in our office and the accessibility of our service.

[1] Who shared their equality information with us.

However, the power to take complaints other than in writing also improves how accessible we are to other groups.

Complaint reference 202405062

We took an oral complaint from a disabled caller whose first language was not Welsh or English. The complaint was about housing repair issues: the shower was not working properly, there were damp and water ingress issues and a faulty extractor fan in the bathroom as well as broken taps. The caller raised these concerns repeatedly with the public sector landlord but to no avail. We spoke to the complainant on the telephone via a family member who acted as a "live translator". We were able to resolve the complaint by agreeing with the landlord that they would carry out the works within a clear timescale. This outcome was only possible because the complainant could speak to us over the telephone, as they would not have been able to navigate a written complaints process

The testimonies of some of the people that we have helped clearly show the human impact of this service:

> *"Immensely helpful. I have dyslexia and wouldn't have been be able to submit a complaint otherwise."*
>
> *"It was really helpful … I'm not really good at filling in forms so couldn't appreciate it more."*
>
> *"The lady on the phone was really understanding and went above and beyond to get my complaint written down accurately."*

Areas for improvement

We want to make sure that everyone who may need to use this service knows about it. Nation-wide awareness research that we commission shows consistently that about three quarters of respondents knew that we can accept complaints other than in writing. Just over a half knew that we can accept a complaint via British Sign Language (BSL).

Figure 3: Proportion of people in Wales who knew they could complain to us other than in writing

Survey respondent group	2020	2022	2024	2025
Knew that they could complain to us verbally	77%	80%	75%	76%
Knew that they could complain to us in BSL	45%	54%	52%	55%

This shows that the level of awareness of this option to complain is generally good, but could still be improved. Therefore, we take opportunities to raise awareness of this power through our outreach and communications channels. However, in doing so, we are always mindful of our capacity as an office, given the 37% increase in our caseload since 2019.

3. Investigations on own initiative

How the PSOW has exercised the power to undertake own initiative investigations and whether this power has provided a mechanism to protect those most vulnerable in society.

Background

Equipping the Ombudsman with the power to undertake own initiative investigations was a new development in Wales. However, these powers were widely and successfully used by ombudsmen throughout the world, for example, by the European Ombudsman and the Ontario Ombudsman. Using the power of an own initiative investigation, these ombudsmen were able to respond to current issues and significantly affect service provision.

With the 2019 Act, we have become only the second ombudsman's office in the UK to be granted this power (the Northern Ireland Public Services Ombudsman has had this power since 2016).

We called for this power first and foremost because we believed that it would help us "give voice to the voiceless" – that is, to deliver social justice for people who are most vulnerable and least likely to complain. However, the ability to undertake wider investigations, in particular, also supports our role to identify systemic improvements in public services, for the benefit of all citizens in Wales.

The 2019 Act grants us powers to undertake two types of own initiative investigations which we refer to as 'extended' and 'wider':

- Extended investigations happen when we are already investigating a problem (the original investigation) and we extend the investigation to other issues or complaints, or to another organisation, not yet complained about (the related investigation). We do this if, during the original investigation, we have a reasonable suspicion of systemic maladministration and when it is in the public interest for us to extend our investigation.

- Wider investigations happen when we conduct a standalone investigation which does not relate to a complaint made by an individual. Our published criteria for own initiative investigations help us to ensure that we only use this power when there is a sound basis and rationale for doing so.

By October 2019, we had developed draft criteria for undertaking own initiative investigations. We laid the criteria before the Senedd in January 2020. You can see our published criteria here.

Step 1: The procedure which we must follow before starting a wider own initiative investigation is set out in section 4 of the Act.

We must

- have regard to the public interest in beginning an investigation

- have a reasonable suspicion that there is systemic maladministration or systemic injustice sustained as a result of the exercise of professional judgement in health or social care cases

- consult such persons as the Ombudsman considers appropriate (in addition to the further consultation set out in section 66 of the Act) and

- have regard to our published Criteria.

Step 2: When we then start a wider own initiative investigation we must follow the procedure set out in section 18 of the Act.

We must prepare an investigation proposal and submit it to the public body we are minded to investigate.

If we decide to extend an original investigation, the requirement to prepare an investigation proposal under step 2 does not apply. We are able to widen the scope of the investigation seamlessly, without the need for the complainant to return to the organisation and submit another complaint or for us to submit a proposal to investigate to the relevant public body, in accordance with Section 18 of the Act. This allows us to undertake a more holistic investigation of concerns without any delay in the process.

When we conclude our own initiative investigations we may make recommendations to the public bodies we have investigated. If we find evidence of systemic maladministration, we are not able to make wider recommendations to other public bodies delivering public services in the same sector. Whilst we 'invite' other relevant bodies to make similar improvements, we have no formal powers to follow up on this, under the Act.

We divide the remainder of our response in this section into two parts, to talk separately about the details and impact of our wider and extended investigations to date.

3.1. Wider investigations

How we have used this power to date

When we decide on the focus of a wider own initiative investigation, we consider whether the matter could impact, especially vulnerable or disadvantaged groups (for example, those who could find it difficult to complain).To date, we have concluded two wider own initiative investigations and both focused on services for highly vulnerable groups – the homeless and unpaid carers. In both instances, third sector organisations were crucial in helping us to identify and shape the focus of our two wider investigations. In particular, the focus of our second investigation, about carers' needs assessments, stemmed directly from our conversations with Carers Wales.

Our **first wider investigation** considered how local authorities conducted homelessness assessments and looked at the work of three local councils – Cardiff, Wrexham, and Carmarthenshire. We originally launched the consultation on this investigation (step 1) in early 2020 and intended to complete that consultation by 10 April 2020. However, with the outbreak of the COVID-19 pandemic, we decided to suspend the process. We reissued the consultation in September and completed it by 30 October. Following our detailed investigation proposal to the public bodies we had decided to investigate (step 2), we commenced the investigation in the first days of 2021.

In October 2021, we published the report on this investigation, entitled 'Homelessness Reviewed: An open door to positive change'. In our report, we praised the work done by these councils during the COVID pandemic and we acknowledged elements of good practice.

However, we identified several serious failings. This led us to make recommendations for improvements by the three Councils that we investigated:

- provide human rights and equality training to officers
- review communication methods
- revise template letters.

We invited the other 19 local councils in Wales to make similar improvements. We also invited the Welsh Government to consider introducing a housing regulator to help standardise practices in relation to homelessness assessments across Wales.

Our **second wider investigation** looked into carers' needs assessments in Wales. We considered whether 4 local councils – Caerphilly, Ceredigion, Flintshire, and Neath Port Talbot - undertook carers' assessments in line with their statutory obligations.

We launched the consultation (step 1) on our draft proposal on 9 January 2023 and completed it by 6 February. Following our detailed investigation proposal to the bodies we decided to investigate (step 2), we commenced the investigation on 6 June 2023.

We published the report on this investigation in October 2024. We found that only just over a quarter (28%) of people in those council areas who identified as carers had received a needs assessment. In addition, only 15% had received a proper support plan

following their assessment. Many carers were also not aware of their rights with regard to assessments and support services that might be available to them.

We identified some areas of good practice by the councils we investigated. However, we also made several recommendations including to:

- improve recording practices
- improve how information is shared with carers
- offer staff refresher training on carers' rights
- collaborate better with the healthcare sector.

As in the case of our first wider investigation, in this instance we also invited the other local councils in Wales to make similar improvements.

Our impact

When we handle complaints, we always check how organisations complied with our recommendations. We have adopted a similar approach to the recommendations deriving from our first wider own initiative report. In 2023, we published a follow-up report, 'Homelessness Reviewed: Revisited'. The report outlined progress made in homelessness services in local councils, based on our recommendations. We found that, while some positive action has been taken by the local councils, there are some areas in which further action could be taken to improve homelessness services across Wales. We publicised these findings widely to help drive further improvement.

Of the complaints officers at local councils that responded to our survey this year, 77% agreed that their organisation was moderately or significantly influenced by our own initiative reports.

Chief Executives and senior respondents to our stakeholder research indicated that, on the whole, our own initiative investigations were an appropriate and constructive power, particularly in areas lacking regulatory oversight, by providing an external eye on public interest issues:

> *"I think the way they went about doing it was quite positive. They engaged with people at the start of the process. They gave an idea of terms of reference. They gathered all the information that ultimately was needed. They gave an*

opportunity to comment on the draft. So from a process perspective, no major issues at all." (a local council representative)

The oversight was seen as an opportunity for meaningful service improvements to be made. However, we refer to some suggested areas for improvement in the next section of this submission.

Third sector organisations that participated in the independent study undertaken for us by Ruth Marks felt that they were only able to comment on the first investigation, as the second investigation was too recent, at that point. Overall, the organisations that took part:

- spoke highly of the investigations and were impressed with the quality of reports produced
- widely supported our recommendations.
- felt that the report into homelessness reviews has stimulated thinking and added weight to policy discussions. For instance, the evidence base of the investigation has been used by the Expert Review Panel convened to review homelessness legislation:

"It was great to have the Ombudsman's report as an independent piece of research to highlight issues from its unique and respected perspective."

"I am impressed by the two areas chosen...homelessness and carers are part of the unheard and unseen as they are maybe not as collectively represented."

One of the organisers of Cardiff and Vale Unpaid Carers Assembly told us that:

"[The report] has really made some difference, it's shone a light, even if it's just a little spark for those of us who are on the receiving end of carers needs assessments or have expectations around how the law relates to the way that services manifest their commitment to it. It's been really, really powerful amongst unpaid carers and clearly there is a lot more work to be done, just to say thank you".

Areas for improvement

While we demonstrate the impact of our own initiative investigations above, we believe that there are ways in which this impact could be strengthened in the future.

The process

We are using this power responsibly and we appreciate opportunities to engage as broadly as possible to ensure that the work we do adds value. However, we believe that the current consultation process that we have to complete to launch a wider own initiative investigation is too long and cumbersome.

This appears to be supported by some feedback from representatives of local councils subject to our own initiative work to date, who indicated a perception that the experience was 'tricky' and 'time-consuming':

> *"I don't think they were clear on what they were trying to achieve when they went into it. We had lots of meetings with them around sort of terms of reference, representations, time frames. The thing ended up taking 18 months plus to bring to a conclusion… by the time they got to the end of it, a lot of the impetus had been lost. We were sort of almost beginning to make improvements because we were aware of what their concerns were as we were going through the process." (a local council representative)*

Our duty under section 4(2)(c) of the Act to consult such persons as the Ombudsman considers appropriate, before starting an own initiative investigation, means that, as well as consulting generally, we consider that this duty requires us to also consult the public bodies we are minded to investigate at this first stage of the process, given their direct interest in the proposal. After this first consultation, we must then also prepare an investigation proposal and submit it to the public body/ies being investigated (section 18(2)).

We have found that the general duty under section 4(2)(c) to consult with 'appropriate' persons in advance of submitting an investigation proposal to the body being investigated prolongs the process and reduces our ability to act as swiftly as we would like, to respond to matters of public concern relating to suspected systemic maladministration. In comparison with the position in Northern Ireland, no such initial general obligation to consult 'appropriate' persons is included in the Public Services Ombudsman Act (Northern Ireland) 2016 – the Northern Ireland Public Services

Ombudsman is required only to prepare an investigation proposal and submit it to the public body it proposes to investigate (see section 6 below). Otherwise, we have a very similar duty to consult other commissioners/ombudsmen as the Northern Ireland Ombudsman, which has been a helpful step in our process (s66 of our Act).

Representatives of local councils and third sector organisations that took part in our research indicated concerns over duplication of efforts, inconsistencies and ‘mixed messages’ arising from different investigations conducted by different regulators. We understand and accept these concerns and would always consult with key stakeholders to ensure that our work adds value. However, the current legal framework is too rigid and prescriptive, hampering our ability to act swiftly when we see evidence that things may have gone wrong for broader groups of people.

The recommendations

Under our own initiative powers, we can make recommendations only to investigated bodies – the specific three local councils we looked at during our first investigation, and the four local councils we selected for the second. The recommendations were relevant to all local councils, but we currently have no statutory power to make wider recommendations. In our reports, we could only invite the remaining local councils and the Welsh Government to take the actions we suggested, but these ‘invitations’ did not have statutory weight.

One local council representative who took part in our research questioned whether we were clear as to whether the recommendations at the end of the review were mandatory or good practice recommendations. They did not believe the recommendations should be mandatory for the four local councils that were investigated if these same recommendations were not mandatory for the other eighteen local councils that were not involved.

This is something that could benefit from further consideration, to maximise the impact of own initiative work.

Investigated organisations

Local council representatives who had experienced our own initiative investigations had mixed responses, noting both positive and critical aspects. Stakeholders sometimes found the experience difficult, time consuming and, occasionally, overly critical due to the use of strong terminology like 'maladministration'. We understand those concerns,

but must underline that the investigative process for own initiative investigations is the same as that for our standard investigations – which means that we can only make recommendations if we find evidence of maladministration / service failure.

Third sector engagement

Third sector organisations that took part in our study welcomed the opportunity to work with us and understood that engagement helped to clarify the scope of the investigation. However, the research helped us identify several areas for improvement:

1. Further develop ways to work with the third sector.

   Make connections with the Third Sector Partnership Council which would improve communication across the whole of the sector and the diverse representative networks at local and national level.

2. Establish regular general and subject specific points of contact.

   Examples include contributing to the People and Housing platform via Shelter Cymru or annual events such as gofod3 (an annual face-to-face event for the voluntary sector).

3. Exchange information on trends and data to highlight ongoing or emerging issues with service delivery.

   Develop a simple system to share analysis of case work and cross reference this with information from the third sector sharing trends, evidence and data highlighting problem areas. Benefits include independently sourced evidence and data and lived experiences revealed by users of front line services. This could be achieved via the points above and also in liaison with the Third Sector Data Unit within Welsh Government.

4. Involve people with lived experience and people working in front line services.

   This would help promote holistic approaches to the delivery of public services and encourage regular engagement between public bodies and the third sector, leading to increased trust and improved service delivery.

5. Increase publicity about the own initiative power.

Leading to greater understanding by individuals and organisations who might wish to draw specific service delivery issues to the attention of the Ombudsman.

While overall public awareness of this power is good, we accept that there is more that we can do to raise awareness among third sector organisations, encourage them to come forward with investigation ideas, and work with them to identify the impact of the investigations and ensure that they lead to tangible improvements in frontline services.

3.2. Extended investigations

How we have used this power to date

To date we have closed 10 extended investigations, with three further investigations ongoing.

Below, we include four examples of these investigations, showing how we can extend the focus on the original complaint to another issue or another organisation.

Complaint reference 202002273

Mr Y complained to us about his wait for prostate cancer treatment at Betsi Cadwaladr University Health Board. During our investigation into that complaint, the Health Board shared with us evidence suggesting there were 16 other patients of urgent clinical priority waiting for their treatment. In previous years, we had seen capacity issues within the Health Board's urology service. Therefore, we had grounds to believe that things may have gone wrong with this service for more patients. For these reasons, we started an extended investigation.

We found that there had been a breach in the Referral to Treatment Times of those 16 patients. This meant that they had to wait much longer than reasonable for their prostate cancer treatment. We also found that the Health Board reported the breach for only half of these patients. The rest of the patients had been referred to England for their treatment, under commissioning arrangements and, at the time, it was not the Health Board's policy to record any breach where a patient was referred elsewhere.

Our findings aligned with those of a critical review by Health Inspectorate Wales, some years earlier. We saw evidence that the Health Board continued to have capacity problems and that waiting time delays led to patients possibly deteriorating as they

waited for treatment. We also found that the Health Board was wrong not to consider whether those patients who had been referred elsewhere had suffered harm.

We recommended that the Health Board:

- reviewed the 8 patients who had been referred to England, to identify if they suffered any harm
- considered those cases through the NHS complaints process (Putting Things Right)
- reviewed its internal harm review guideline
- referred our report to its Board of Governance to consider capacity and succession planning within its urology service.

We would not have been able to identify the continued capacity issue and more widespread potential harm without the ability to conduct an extended own initiative investigation in this case.

Complain reference: 202207320

Mr B complained to us about his dental care and removal of a tooth by a Dental Practice in the area of Swansea Bay University Health Board. Mr B then told us that the Practice had subsequently refused to treat him because of the complaint investigation. We extended the investigation to robustly consider the events leading to the tooth's removal and also to consider the possibility that Mr B was denied access to dental care because he had complained to us.

We did not find failings in Mr B's dental care. However, we decided that there were shortcomings in how the Practice communicated with Mr B. It was also not right for it to refuse to see Mr B as a patient after he had made a complaint. These findings would not have been possible, had we not extended the investigation, as Mr B would have needed to make a fresh complaint about this issue, without which we would not have identified opportunities for improvements in how the Practice approached complaints.

Complaint reference 202205146

Mr L complained to us about his late wife's (Mrs L's) care by Hywel Dda University Health Board. We decided to extend that investigation, using own initiative powers, to

also look at the care provided by the Swansea Bay University Health Board. This was because Mrs L was receiving renal services from Swansea Bay University Health Board and we decided that it would not be possible to fully investigate the complaint before us without also looking at that aspect of care.

We ultimately found no fault with the care provided by Swansea Bay University Health Board. However, we were able to robustly investigate and make findings in relation to the original complaint. We also saved Mr L the need to go through the complaint process again. That would not have been possible without extending the investigation.

Complaint reference 202202525

Ms C complained that Swansea Council had failed in its duty to safeguard her two children following a referral made to it by a local authority in England (which was under investigation by the Local Government and Social Care Ombudsman - LGSCO). Ms C and her children had moved to the Council's area, following the breakdown of her relationship with their father, but they retained contact with him (including overnight stays at weekends). During our original investigation, and from information provided by the LGSCO uncovered during its investigation, we extended the investigation, using the own initiative power to consider the Council's action during an earlier period.

Whilst we ultimately found that the Council's actions during the earlier period (own initiative investigation) were reasonable and in line with relevant guidelines, we found that there was a failure to act on information subsequently provided to the Council and we made recommendations to the Council, including to review its processes and train staff. Our own initiative investigation allowed us to consider the events holistically and provide assurance that the Council's action during the earlier period were appropriate.

Our impact

The value of our power to extend ongoing investigations is that it helps us to bring to light things that may have gone wrong without forcing members of the public to repeat a lengthy complaint process. We include below examples of two cases to illustrate the impact of this power on the people affected:

Complaint reference 202205543

Mr D had complained about his wife's, Mrs D's care and treatment in 2019 at Betsi Cadwaladr University Health Board. He said that there had been a delay in the surgery to remove her appendix and that the Health Board did not investigate her breathing

difficulties in a timely way. Following this, Mrs D had suffered a cardiac arrest, requiring a lengthy Intensive Care admission. This had significant impact on her daily life, once discharged from hospital.

Although Mr D complained about the events in 2019, we saw evidence that Mrs D underwent an earlier scan, relating to her appendix, in 2017. We wanted to check whether the Health Board should have considered the removal of her appendix then. We extended our investigation to look into that. We found that the Health Board did not arrange a follow up for Mrs D after the 2017 scan, and missed the opportunity to remove her appendix, then. Had that taken place as a planned procedure, Mrs D would not have needed an emergency surgery in 2019 and the resulting complications may not have happened.

We noted in our report at the time that Mr and Mrs D were entirely unaware of the missed finding on the 2017 scan and the problem was not identified during the Health Board's investigation of their later complaint. Had we not extended our investigation, this significant failing leading to serious injustice to Mr and Mrs D would otherwise not have come to light.

Mr D told us:

"The Health Board didn't want to know until the Ombudsman got involved and after I complained it 'clammed up'. … I would never have found out that my wife's appendix problem should have been dealt with sooner but for the Ombudsman's investigation. I know that this was only possible because of the extra powers given to the Ombudsman a little earlier. In my opinion the office needs all the powers it can get to get to the bottom of things for everyone, as they did in my wife's case."

Complaint reference 202005941

Mrs E complained about the care provided to her late mother (Mrs F) in 2020 by a GP practice in the area of Cwm Taf University Health Board. Mrs F was suffering from increasing pain in her lower leg. … We upheld the original complaint about delays in Mrs F's referral.

However, when we looked at the clinical records, we were concerned about how the Practice prescribed antibiotics and diuretics to Mrs F. We extended our investigation to look into this. We found that the prescribing practice was contrary to clinical guidance and was likely to make Mrs F feel worse. Furthermore, it was quite risky for Mrs F to

take the diuretics prescribed, as she was already taking a combination of medications at the time. Overall, these prescribing failures raised concerns about wider patient safety at the Practice and contributed to Mrs F's acute kidney injury, which prevented her from undergoing surgery on her leg later on.

Mrs E told us:

"I am eternally grateful to the Ombudsman for the way my case was handled and without that help I would not have been able to pursue what I did, gain answers and help me to now move on. I was so glad the Ombudsman had those powers (to extend the investigation) as, at the end of the day, being able to get the outcome the Ombudsman did has finally given me some peace of mind. It was devastating to know that my mum suffered the way she did, but good to be vindicated in making the complaint as I knew something wasn't right.

I would hate to think that other people in a similar situation to me wouldn't have the reassurance to pursue things further with the Ombudsman if powers were taken away, as where would they then go to get answers? They need all the powers they can get, in my view. I cannot say enough about how grateful we were as a family to the investigator who took on my case and then went further to gain the answers. We were kept informed throughout, and knew it would take some time. We were very pleased with the outcome and only because I know the whole truth about what happened with my mother's care do I feel able to now speak about it and move on."

4. Power to investigate private medical treatment

The effectiveness of PSOW's ability to investigate private medical treatment (including nursing care) in a public/private health pathway.

We note that the terms of reference includes a reference to our investigation of privately funded nursing care. For clarification and avoidance of doubt, we have held powers to investigate private nursing care in care homes, by domiciliary and independent palliative care providers since November 2014 (the formal implementation date of the power introduced by the Social Services and Well-being (Wales) Act 2014).

Since the introduction of the Act in 2019, in quite specific and limited circumstances, we are able to investigate private healthcare. This is when alleged service failure in the delivery of NHS care cannot be investigated effectively or completely without also investigating 'other health related services'.

Prior to the introduction of the 2019 Act, it was estimated that around 1% of health sector complaints received by us each year would contain an element of private healthcare. It was therefore always considered that this power would be used sparingly, whilst futureproofing the remit of the office, should complaint trends change.

In fact, we have not yet had to use the power to investigate private healthcare, as we have not received any complaints that have met the requirements set out by the Act which reach our threshold for investigation.

That said, we firmly believe that the rationale for the Ombudsman to retain this power remains as strong as ever. With the ongoing effects of the COVID pandemic, increasing pressure on the NHS and more citizens paying for some elements of their care when facing lengthy waiting times, there may yet be small numbers of cases where elements of private healthcare will need to be investigated as part of our investigation of NHS healthcare. As such, we believe that this power remains important in ensuring access to justice for citizens in Wales.

The factsheet on our website explains clearly our role and remit in relation to privately funded health care for service users. We published this factsheet when the Act took effect.

5. Complaints standards work

PSOW's role in relation to complaints handling standards and procedures and the extent to which the 2019 Act provisions have improved complaints handling by bodies within PSOW's jurisdiction.

Background

Good complaint handling is an essential element of good administration. Over the years, we have seen consistently that a noticeable proportion of complaints reaching our office relate to complaint handling by public bodies.

While generally we welcome and encourage complaints, our hope was that improvement in public service complaint handling practice would be likely to reduce the number of complaints *about* complaint handling reaching our office.

Ultimately, however, we wanted the main beneficiary to be the Welsh public — with less time, effort and frustration being expended on 'putting things right' directly with the bodies concerned. This is why, as part of the reform of our office, we called for the strengthening of our powers to drive improvement in complaint handling.

How we have used this power to date

Once the 2019 Act received Royal Assent, we immediately worked to establish our Complaints Standards team, which was fully in place by August 2019. We embarked on a widespread programme of engagement. The purpose of this programme was to understand the challenges faced by different public bodies, to highlight and share existing good practice, and to identify any barriers to improving performance.

Following a public consultation, we laid before the Senedd our draft Complaint Handling Statement of Principles, and issued our Model Complaints Handling Policy and accompanying guidance. These documents were approved in January 2020.

The formal launch of these documents and the first tranche of training events had to be delayed, due to the COVID-19 pandemic. Nevertheless, the Complaints Standards team was able to proceed with another strand of its work – gathering the data on complaints handled by some of the organisation in our jurisdiction. In 2021/22, for the first time, we published this data for local councils.

By today, **54 public service providers** across Wales operate our model complaints policy. These organisations – including all local councils, all Health Boards, Welsh Ambulance and most Housing Associations - represent about 85% of the complaints which we receive. We have targeted these bodies to adopt the policy first, to provide the most benefit to people using their services.

Eventually, our model policy will apply to the entire Welsh public service – realising our vision of "one complaints journey, regardless of where you live or who you are complaining to".

Since September 2020, we have provided **more than 550 training sessions**. Our training has now reached **over 10,000 people**.

Since 2020/21, we have also regularly **published data** on complaints handled by local councils and then also Welsh Health Boards and Trusts. This data is now published twice a year.

Our impact

Our training is almost universally well received by public service providers:

> *"Probably one of the best training events I have attended and even though it was my first remote session everyone still managed to participate fully."*
>
> *"It was the first training I've had in a long time where I come from it thinking it was really worthwhile and beneficial to my role. It was so interactive, I really enjoyed it."*
>
> *"Since the training I am trying to change my behaviour so that I listen to incoming calls with an open mind and not type up the log notes before they have finished speaking"*
>
> *"My many thanks for the training sessions. They really did make me think very deeply about how we respond to clients"*
>
> *"Made me realise how important the process is in supporting not only those individuals that wish to make a complaint but also how it supports us an authority in ensuring continuous improvement."*

> *“I really enjoyed this training session. It has taught me the importance of acting on a complaint straight away, contacting the customer and listening to their individual concerns and trying to sort out a resolution but at the same time given the customer the confidence that we care for them and that we are willing to listen.”*

Of the complaints officers that responded to our survey this year:

- 97% agreed that we provide good quality guidance about complaint handling
- 79% agreed that we provide good quality training about complaint handling.

Chief Executives and senior respondents to our stakeholder research reported high levels of engagement and satisfaction with our complaints standards training. They indicated that our complaints standards work had led to improvements in organisations’ complaints handling as well as in staff’s understanding of our processes:

> *“The conversations we've had with the Ombudsman I think gave us a clear focus about how we handle those complaints that do go into Ombudsman, how do we make sure that they are as effective as possible? But also how do we make sure our overall process for all complaints and concerns is as inclusive and easy for people to use as possible so that we try and minimise the sort of numbers that will end up going into an Ombudsman process.” (a Health Board representative)*

> *“We had a big batch of training probably about six months ago now and we've just reached out recently. So part of us looking at trying to improve again is to get some more training, repeat for some people, new for people who have joined the organisation. So yeah, the training was good…. The training has been a step in the right direction in breaking down barriers and fears about the Ombudsman.” (a Housing Association representative)*

Another significant benefit of our complaints standards role is the availability - for the first time – of regular, reliable and comparable data on complaints across the public sector. Not only does this ensure that public bodies comply with our model policy, it also promotes better focus by public bodies on using complaints information to improve service delivery for everyone, not just those with the means and ability to complain.

Our complaints standards work has undoubtedly improved reporting standards – with better recognition of what constitutes a complaint increasing numbers of complaints being logged by local authorities and Health Boards:

> *“I think it's made it visible ultimately that there are different rules and processes. So when we've had the opportunity to be able to revise and review our internal processes, we've always got a framework now ultimately in which to measure it against to ensure that we're meeting those requirements at the same time. So yes, naturally it has.” (a local council representative)*

The data allows us to better understand how service providers deal with complaints. For example, it enables us to look at what proportion of complaints considered by these organisations is then referred, or escalated, to our office. This helps us understand how effective the organisations are in resolving complaints. This proportion has decreased slightly for local councils since 2021/22, which could reflect greater satisfaction that complaints have been properly considered and responded to by the councils. However, we saw a small increase in the referral rate of complaints about Health Boards.

Another measure of impact of our complaints standards power is our intervention rate. Intervention means that we found that the body made a mistake and it needed to put things right. We can intervene through Early Resolution or after investigating. In general, we would want our intervention rate to be low. Our intervention rate in complaints about local councils and Health Boards has remained broadly similar since we launched the complaints standards work. However, our complaints trends halfway through the current financial year could suggest a reduction in our intervention rate for both sectors.

Figure 4: Our complaints standards data: local councils

Local councils	2021/22	2022/23	2023/24	2024/25 (April to September only)
Number of new complaints logged	15,307	15,525	18,276	10,957
Proportion of complaints upheld	44.96%	41.12%	47.45%	51.67%
Proportion of complaints referred to us	8.01%	7.09%	6.28%	7.04%
Our intervention rate	14%	13%	14%	12%

Figure 5: Our complaints standards data: Health Boards

Health Boards	2021/22	2022/23	2023/24	2024/25 (April to September only)
Number of new complaints logged	-	18,901	19,062	9,353
Proportion of complaints referred to us	-	5.22%	5.51%	6.41%
Our intervention rate	-	30%	31%	27%

However, it is most important that our complaints standards work leads to improvements for the Welsh public. The results of our national survey point to some positive trends in that respect. Since 2020, we have seen an increase in the proportion

of people who complain to local councils, healthcare providers or social landlords (17% in 2025). However, we have also seen an increase in the proportion who said that it was easy to make a complaint (72%) and that they were happy with how the complaint was resolved (47%).

Figure 6: Proportion of respondents who complained to local council, a healthcare provider or a social landlord (e.g. housing association) within last two years.

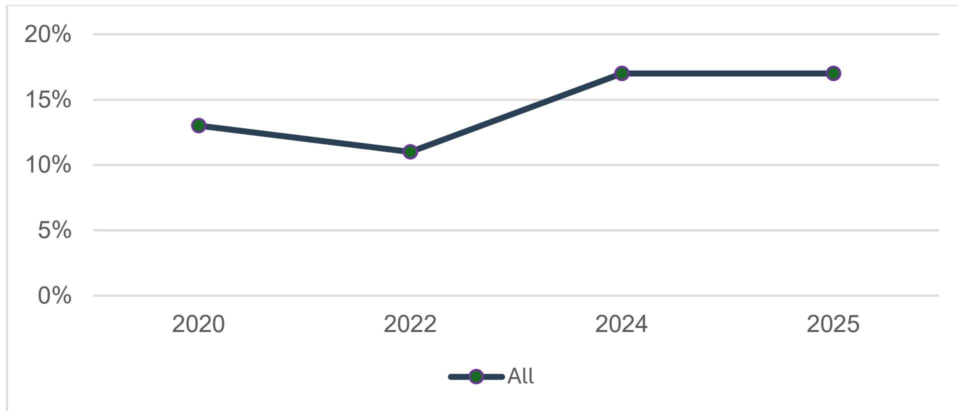


Figure 7: Proportion of respondents who complained and said that it was easy to make a complaint.

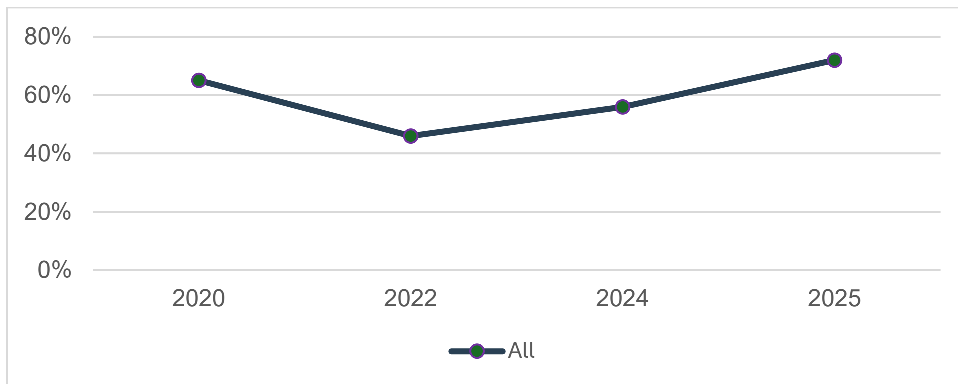
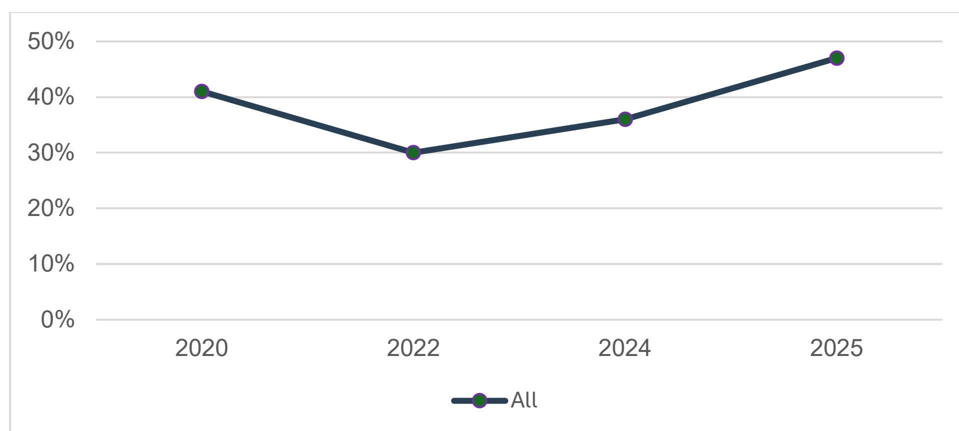


Figure 8: Proportion of respondents who complained and were happy with the way the complaint was resolved.



Areas for improvement

Complaints officers and Chief Executies/senior respondents to our stakeholder research were generally supportive of our work but indicated some areas for attention in the future:

- challenges related to resources and workload when adhering to our complaints standards
- ensuring there are no inconsistencies in complaint recording data
- a scope for a more cooperative partnership with us and a collaborative development of new approaches
- benefits of limiting bureaucracy as far as possible
- appetite for more refresher sessions as well as more bespoke training, tailored to the issues relevant to each sector
- targeting training towards GP practices.

We will continue to engage with public bodies and the Welsh Government to ensure that our statutory principles of good complaint handling are:

- consistently applied by public bodies in Wales
- properly considered as part of any policy decisions which have the potential to affect how complaints are handled by public bodies in Wales.

We will also continue to engage and collaborate with other regulatory bodies and the Commissioners in Wales to support their work and to create greater standardisation in good complaint handling across the Welsh Public Service.

6. Our Act and the broader ombudsman sector

How the Act compares with current best practice.

PSOW is already seen as a leading light amongst UK Ombudsman organisations, given the suite of powers in the Act. We are certainly the envy of England, whose jurisdiction remains wedded to legislation originally passed decades ago (in 1967 and 1993 in the case of the Parliamentary and Health Service Ombudsman (PHSO) and 1974, in relation to the Local Government and Social Care Ombudsman). In some instances (relating to complaints about UK government departments), complainants face an additional hurdle of needing to file a complaint through their MP (known as “the MP filter”). Despite initial proposals to introduce new legislation in England, these have not borne fruit and all complaints about public services have to be made in writing.

Whilst working with bodies to establish good complaint handling practice, neither the PHSO or the LGSCO in England have statutory powers in this regard and therefore have no statutory power to set complaints standards.

Whilst having more recent governing legislation (2002), complainants in Scotland also still have to submit complaints in writing. The Scottish Public Services Ombudsman has complaints standards powers and has worked to establish a model complaints process, as well as delivering training to public bodies.. Scotland charges fees for their courses, which we in Wales deliver to public bodies free of charge. The benefit of the training can be seen from the feedback already referred to above.

Neither England nor Scotland can undertake own initiative investigations.

It is only Northern Ireland, with its more recent legislation, that can, like us in Wales, take oral complaints, undertake own initiative investigations and has complaints standards powers. Like us, Northern Ireland has used its own initiative powers sparingly, but has a more streamlined process (see section 3 above).

Equipped with the suite of proactive powers, we remain at the forefront of best ombudsman practice in the UK and internationally.

7. Policy objectives of the 2019 Act

The extent to which the policy objectives of the 2019 Act have been met and any developments in the five years since the Act was introduced.

In the previous sections of this submission, we talked in detail about the impact of our proactive powers to date. Here, we briefly highlight how that impact aligns with the policy intent of the 2019 Act:

- **Improve social justice and equal opportunities**

  Our ability to accept complaints other than in writing improves access to our services and so strengthens our ability to secure administrative justice. As we show above, analysis of our casework clearly shows that this service supports disabled people. Case studies show that this service also improves access for other groups.

  Our complaints standards training includes a detailed discussion on accessibility – and how public bodies can ensure they receive all the complaints they should, from all parts of society. This helps to contribute to our ambition to positively influence the accessibility of local complaints processes. Under our complaints standards powers, we have also reached out to local councils to query what arrangements they have in place to monitor who complains to them. We believe that this information is key if public service providers are to ensure that their complaints processes are accessible.

- **Protect the most vulnerable**

  We know that many groups may find it difficult, or be reluctant, to complain, for example, due to lack of awareness or capacity to engage with complaints process; issues around trust, fear of reprisals or disillusionment with public service providers.

  The power to undertake an own initiative investigation allows us to focus on matters that benefit those most vulnerable in our society, those who do not, or

are unable to complain; the seldom heard voices. This consideration is central to the statutory criteria underpinning our wider own initiative work.

To date, we have concluded two wider own initiative investigations and both focused on services for highly vulnerable groups that rarely complain to our office – the homeless and unpaid carers.

Our criteria also ensure that we use this power wisely and only when we have a sound basis to do so.

We have also used our power to extend existing investigations to look at other issues or organisations. We give examples of human impact of this power earlier in this document, as we are able to investigate more holistically and spare people having to repeat complaints processes.

- **Being more responsive to the citizen**

  The COVID-19 pandemic has emphasised how important the own initiative powers are to any ombudsman service, if it is to take a proactive approach to improvement. By using this power, we were able to make a 'real time' difference for disadvantaged groups. We have outlined above, in section 3.1, how small changes to our general consultation duty could equip us to become more responsive to citizens in Wales on issues of public concern.

  Our power to investigate private health-related services, in some limited circumstances, is designed to ensure that the complaints process will follow the citizen and not the sector. As we explain in section 4 above, we have not used this power to date, as we have not received any complaints that met the requirements set out by the Act which reached our threshold for investigation. Nevertheless, we firmly believe that the rationale for the Ombudsman to retain this power remains as strong as ever.

- **Driving improvement in public services and in complaint-handling**

  The availability of regular, reliable and comparable data on complaints across the public sector drives accountability and better practice. The organisations already under our complaints standards remit indicate high levels of satisfaction with our complaints guidance and training and generally agree that this power has a positive impact on their complaints processes. Since the launch of our

complaints standards powers, we have also seen an increase in the proportion of the Welsh public who said that it was easy to make a complaint and that they were happy with how the complaint was resolved.

- **Contributing towards the achievement of well-being goals**

  Although we are not subject to the requirements of the Well-being of Future Generations (Wales) Act 2015, our work since 2019 contributes to some of the goals set out in that Act:

  - a healthier Wales – health continues to be the subject of the largest group of complaints we receive. Our complaints standards work and other efforts (such as our thematic reports) supports wider learning and improvement of health services in Wales.

  - a more equal Wales – through accepting complaints other than in writing, and monitoring complaints processes and the performance of other organisations, we improve access to public services. Our use of own initiative powers enables us to investigate issues affecting those who are least likely to complain, addressing the imbalance of power between organisations and individuals.

  - a Wales of Cohesive Communities – our use of own initiative and complaints standards powers helps us to identify and 'call out' differences in service quality across Wales.

  - a Wales of vibrant culture and thriving Welsh Language – we can accept complaints other than in writing in Welsh as well as other languages. This service can support those who are more confident speaking than writing in Welsh.

8. Cost and benefits and value for money

The costs and benefits of the 2019 Act, how these compare with the estimates set out in the Explanatory Memorandum and whether value for money been achieved.

The preceding sections discussed in detail the impact of our powers and how we have met the policy objectives of the Act. This section focuses on costs and the value for

money of the Act, with reference to the original Regulatory Impact Assessment (RIA). The RIA only set out estimates for a 5 year period (2019-20 to 2023-24), therefore only direct costs up to 31 March 2024 are included in our analysis below and assessment of value for money.

We have reported each year as part of our Annual Report & Accounts our expenditure on activities related to the Act. The total direct costs, as reported over the last 5 years, are summarised below:

	£000
Staff Costs	1,381
Premises	65
Communications	39
Computer Services	35
Office Costs	15
Training & Recruitment	11
Capital	8
Advisory & Legal	6
Travel & Subsistence	4
Total	1,564

Each year, we have reported a small under-spend against our budgeted expenditure on activities relating to the Act. The total under-spend over the last 5 years on activities relating to the Act was £95k, which means we have effectively used just under 95% of our allocated additional funding as set out in the RIA. All under-spends are repaid to the Welsh Consolidated Fund.

Overall actual costs have been lower than those allowed for in the RIA, as we have one dedicated member of staff who leads on our own initiative work, with support from other staff across the office, as required (rather than the two members of staff assumed in the RIA) and travel and subsistence costs associated with our Complaints Standards work have been significantly lower due to ongoing changes in working practices, as a result of the COVID pandemic.

Whilst the above table relates to our expenditure since 2019/20, it should also be noted that, by the end of the 2023/24, PSOW had provided more than 552 training sessions to public bodies, completely free of charge. The value of this training on the private market would be in excess of £1million.

We have continued to prudently deliver these services through 2024/25. The benefits that have arisen from how we have utilised this money have been explained in this evidence submission and demonstrate how we have effectively obtained value for money through maximising the output of the resources invested. We will continue to report on the benefits and identify expenditure related to the additional powers provided to the Ombudsman under the Act, as part of our Annual Report & Accounts.

Michelle Morris
Public Services Ombudsman for Wales
March 2025

Appendix A – Independent Report by Ruth Marks CBE on the views of the Third Sector organisations in Wales on Public Services Ombudsman for Wales Own Initiative Investigations 2021-2025

Appendix B – Stakeholder Research - Chief Executives or Senior representatives of local councils, Health Boards and Housing Associations.

Final report

Independent report on views from Third Sector Organisations in Wales on the Public Services Ombudsman for Wales Own Initiative Investigations 2021-2025.

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Executive summary

In 2019 the Senedd enacted a new Public Services Ombudsman (Wales) Act. One of the new powers gave the PSOW an Own Initiative power of investigation under s4 of the Act. The purpose of the power is to enable the Ombudsman to undertake a Wales wide investigation of the delivery of a chosen public service. The outcome of the investigation is to indentify how services can be better delivered to people across Wales.

Since the Act was introduced, the PSOW has undertaken two Own Initiative investigations which can be found on the website here:

Homelessness Reviewed: an open door to positive change.

Are we caring for our carers? An Own Initiative investigation into the administration of carers' needs assessments in Wales.

In responding to the Senedd's Finance Committee investigation of the operation and effect of the new powers which were introduced in the Act, the Ombudsman commissioned an independent project to gauge feedback from Third Sector organisations who work either in direct ways to protect those most vulnerable in society or provide information to charities and groups delivering advocacy support.

The independent project was undertaken by Ruth Marks CBE, (former Chief Executive of WCVA) between February and March 2025 and the main findings are summarised below.

Third Sector organisations are active across every part of Welsh life and many work closely with public services. Some charities and voluntary organisations provide direct services to people who are in vulnerable circumstances and have significant expertise relating to all equality characteristics. Staff and volunteers provide support to people facing disadvantage, discrimination and inequity in service provision.

The size and scope of Third Sector organisations varies, however commitment and determination are constant. This is reflected in the positive response from Third Sector organisations approached for this project to discuss and reflect upon the Ombudsman's Own Initiative investigations.

The Third Sector have made a crucial contribution to the investigations undertaken to date, drawing on their experience of working with vulnerable people and groups in every community across Wales. Charities and voluntary organisations support people who feel let down by public services, people who have faced multiple difficult life events, disadvantages and trauma and as a result have very low trust in official systems and processes.

The Ombudsman is focussed on improving public services by addressing maladministration. Increased collaboration with the Third Sector would be mutually beneficial, but most importantly, result in better support and services for the most vulnerable in society.

Wales is the only country in the UK with formal systems of engagement between the Third Sector and Government. This report highlights real potential to build upon these systems with the Ombudsman, the wider public sector and the Third Sector. This would demonstrate value for money and increased democracy in line with national policy commitments and the principles of social partnership.

The process of making a decision to undertake an Own Initiative investigation.

The decision making process involves several stages including casework analysis, scoping the issue, consultation with public bodies and wider stakeholders resulting in a focussed proposal. This process takes some time before an actual investigation can begin.

There was unanimous support across the organisations consulted that the Own Initiative investigation powers offered an essential and valuable additional level of scrutiny of public services.

One contributor said "*I am* impressed by the two areas chosen...homelessness and carers are part of the unheard and unseen *as they are* maybe not as collectively represented."

The experience of engaging with PSOW throughout the Own Initiative investigation process.

Third Sector organisations welcomed the opportunity to work with the Ombudsman and understood that engagement helped to clarify the scope of the investigation, the accuracy of findings and the focus of recommendations.

One stakeholder said "We would always see being asked by the Ombudsman for information as a really positive engagement that we would prioritise."

Third Sector organisations noted that their front line services see injustices happening and are therefore well placed to engage with the Ombudsman sharing relevant evidence and data.

All organisations agreed that service user involvement is vital, and diversity amongst these voices is of the upmost importance. Therefore they welcomed the approach taken by the Ombudsman to put users views at the heart of investigations, and felt this was achieved by the Ombudsman consulting and collaborating with them throughout the process.

One stakeholder reflected the views of many of those consulted: "Thank you so much for thinking of us and reaching out to us because we do value the engagement and we do value the initiative reports as well."

Perception of the impact of the investigations and whether the scope of the recommendations are supported.

The first investigation into homelessness investigations took place in 2021 and the second investigation into carers needs assessments was completed in 2024.

In relation to understanding impact, the Third Sector organisations felt that they were only able to comment on the first investigation, as the second investigation is too recent.

Importantly the report into homelessness investigations has stimulated thinking and added weight to policy discussions. The evidence base of the investigation has been used in expert reference groups and influenced legislation.

Several Third Sector organisations spoke about the Expert Review Panel convened to review homelessness legislation. The Panel referred in detail to the Own Initiative Investigation report in the course of their work.

"*It was* great to have the Ombudsman's report as an independent piece of research to highlight issues from its unique and respected perspective."

Stakeholders who took part spoke highly of the investigations and were impressed with the quality of reports produced. A positive outcome is that the recommendations of both investigations were widely supported.

Third Sector organisations were keen to know how the Ombudsman would hold public bodies to account. They wanted the impact of the Ombudsman's reports and recommendations to be monitored over time to evaluate whether they were making a positive difference to people's lives and improving their experience of public services.

Opportunities for improvement

1. Further develop ways to work with the Third Sector.

2. Establish regular general and subject specific points of contact.

3. Exchange information on trends and data to highlight ongoing or emerging issues with service delivery.

4. Involve people with lived experience and people working in front line services.

5. Increase publicity about the Own Initiative power.

Feedback from the organisations consulted

1. How Third Sector organisations perceived the process by which PSOW decide what to investigate (or what not to investigate)

Shelter Cymru

Understanding that the process drew information from casework trends to identify key issues providing valid reasons for assessment and investigation.

With technical areas of legislation and regulation it is often hard to take a detailed view to find out if the policy intention varies from the practice on the ground. However, when injustices are happening, the opportunity to look closely becomes even more important.

The PSOW staff were very positive about receiving data and evidence from the policy and casework teams of Shelter Cymru.

Llamau

The investigation process adds to democracy and therefore is essential to good practice.

There was significant discussion about the complexity of homelessness and the need to agree on the most important aspects of the investigation.

Increased collaboration during consultation and proposal stage might have been useful, helping to tighten the boundaries and focus of the investigation.

Crisis

Positive experience and pleased to be able to contribute to an independent investigation that looked at service delivery from a different perspective.

Carers Wales

Process was positive because the investigation dealt with more than an individual case and was able to look at wider and systemic impact.

The actual detail of this Own Initiative Investigation came from a stakeholder engagement event / sounding board event involving carers organisations.

Round Table

There was a varied understanding about the detail of the investigation process.

Some Third Sector organisations were aware of an understood the consultation, proposal and investigation process.

These organisations tended to be larger charities and Third Sector organisations with dedicated campaigns and policy functions based in Wales. However, smaller organisations had less knowledge of the process, but were confident and assured that the Ombudsman could undertake such investigations.

All agreed that the process allowed for issues impacting inequalities to be looked at more holistically.

Organisations recognised the considerable benefits of learning from casework investigations and a focus on 3 or 4 public bodies geographically spread across Wales.

They were keen to learn more and in future would like to develop ways to share information from lived experience that could help delivery of public services to people who face multiple disadvantages and discrimination.

Carers organisations pointed out that at the same time as the PSOW investigation into carers needs assessments, similar work was being undertaken by Care Inspectorate Wales and a Ministerial Advisory Group. It was therefore felt that this created additional work for Third Sector stakeholders and potential duplication of effort and some confusion.

2. Experience of engaging with PSOW throughout the Own Initiative investigation process - from sharing ideas about areas to investigate through to supporting the office with evidence and gathering feedback on impact.

Shelter Cymru

There was considerable positive engagement with individual staff to share data and evidence. A useful focus group was convened which gave the opportunity to share first hand lived experience. It has been possible to monitor impact over the several years since the investigation. It is important to note that good collaboration needs time and resource.

Llamau

After initial discussions, there was less direct involvement due to resource constraints. The timeframe of the scoping exercise was felt to be too long and this was frustrating.

Crisis

Noted that they had a positive experience of working with the Ombudsman and in future would value and prioritise the opportunity to provide further information when consulted.

Carers Wales

Their involvement in the investigation was a very positive experience and they felt that PSOW staff were receptive to receive data and evidence from the organisation and from carers. They were able to facilitate service user involvement which in turn helped meet one of their own strategic priorities for carers to directly influence policy and practice.

Carers are less likely to make an individual approach to PSOW than other groups. The engagement collaboration with the PSOW helped build the picture and highlight differences and gaps in service delivery across Wales.

Round Table

Smaller organisations felt they were being asked for a considerable amount of information and this placed additional strain on already stretched resources. These organisations know that the people they support are less likely to directly approach the PSOW.

Of critical importance is that they highlighted a concern that some public bodies are pulling back from engagement with the Third Sector. This is seen as detrimental to sharing knowledge and ideas to improve services for people in vulnerable circumstances.

One organisation commented “It was all quite smooth”.

However, levels of time and resources available to the organisations varied considerably. This resulted in larger organisations being better able to provide the evidence, data, research and case studies to the Ombudsman’s investigation. Feedback indicated that they greatly valued the opportunity to share their work.

Smaller voluntary organisations felt rather overwhelmed with the volume of information they were asked to provide. They have very useful evidence to share, however, due to the crisis driven nature of their work, do not have any spare capacity to maintain engagement in lengthy processes. Feedback indicated a strong desire to be involved in investigations, but it would help if the consultation and engagement processes could be more precise and focussed on what information would be the most useful in evaluating the most important impacts of service delivery.

3. **Perception of the impact so far - or, if the recommendations are too recent to comment, whether the scope of the recommendations are supported**

Shelter Cymru

As a result of the Own Initiative Investigation being evidence based, the Expert Review Panel into Ending Homelessness was able to draw information from the PSOW report. The work has informed and expanded policy discourse.

Specific impacts were noted: an increase of time from 56 days to six months which provides a greater opportunity to review the aspect of “reasonable steps”. Another concerned the timeframe for a review around temporary accommodation being reduced from 56 days to 21 days which has a positive impact for people facing homelessness.

Some Local Authorities clearly take a holistic, trauma informed approach and others do not. Involvement of the Take Notice function / service is having an impact in some areas across Wales.

As PSOW is independent of Welsh Government and public bodies there is an opportunity to involve people with lived experience in considering the effectiveness of a public service.

Llamau

Less convinced that there has been significant impact. Recommendations could have been more hard hitting.

Crisis

Reinforced many of the points made by Shelter Cymru and noting that Crisis were the organisation who convened the Expert Review Panel looking into changes to housing legislation and drew on the Ombudsman's report.

This stakeholder engaged with the Ombudsman and was also a member of the Expert Review Panel. They highlighted the ability to refer to particular issues "I was able to do that in large part because of the Ombudsman's work, because people knew what I was talking about and …it didn't just sound like a random idea out of nowhere, but it had an evidence based behind it. It seems likely that some of those reforms will go forward."

The report is available here: https://www.crisis.org.uk/media/uqgbuwpp/ending-homelessness-in-wales-a-legislative-review.pdf

A key point to note is that as the Investigation had an evidence base behind it, members of the Expert Review Panel were able to refer to this in the course of their considerations around proposed legislative reform that is anticipated in the near future.

In addition, in relation to the recommendations of the Ombudsman's report "…some of them have informed the White Paper, which is absolutely great. It's definitely stimulated thinking about where the weaknesses were."

Carers Wales

The report has added weight to key issues. Very useful to show multiple angles and make links to the Track The Act survey (Social Services and Wellbeing (Wales) Act 2014.

The detailed work with investigated authorities was useful and especially the ability to highlight deficiencies in data collection.

Round Table

The PSOW needs to consider how to publicise its work more widely as some organisations were not aware that the investigated authorities are required to respond to the report.

Stakeholders were reassured that those bodies are obliged to respond and that the PSOW follows up the investigation after a period of time.

Feedback supported the focus on individual and practical outcomes rather than process and tick box activity.

Recommendations were seen as useful support for improved advocacy of service users interests.

4. How the Ombudsman's Own Initiative work could be improved, whether in terms of the length and complexity of the process, engagement with the communities affected or tracking of impact

Shelter Cymru

Recommend increased engagement with front line colleagues as they have first hand experience and directly relevant information to share. It would be useful to connect with Third Sector organisations using shared platforms to ensure comprehensive communication – e.g. People and Housing Conference event and mailing lists.

Llamau

Develop a more collaborative approach to scope and methodology. Consider a joint steering group to identify critical issues and focus on what causes the most trauma.

Crisis

Recommended follow up reports consider both the investigated authorities and other Local Authorities and Welsh Government to achieve greater impact.

Carers Wales

Ensure clear understanding about the process to contact individual service users. The charity had contacted a number of carers who agreed to be involved in the investigation. The PSOW contacted some of the group, but not all. When the carers not contacted asked the charity about this, they were not aware and this put staff in a difficult position. Clarity of numbers required, who will contact who and when is vital.

Round Table

Communicate at regular intervals via established networks and systems which exist across the general Third Sector and within specialisms including homelessness, carers, and equality characteristics.

Clear language and the same terminology should be used – e.g. Carers Needs Assessments also called What Matters conversations, and this causes confusion in the whole system.

Consider link to Own Initiative investigations on home page of PSOW website. Language used is not immediately clear or understandable. Investigation on Own Initiative is correct regarding legislation, however this is not the most accessible language - in depth investigations might be one option?

Clearer branding of this important power would help service providers and users to better understand its relevance and possible impact on their lives.

It would be useful for Welsh Government to consider a dedicated written or oral statement in response to an Own Initiative Investigation report.

Opportunities for improvement

1. Further develop ways to work with the Third Sector.

Make connections with the Third Sector Partnership Council which would improve communication across the whole of the sector and the diverse representative networks at local and national level.

2. Establish regular general and subject specific points of contact.

Examples include contributing to the People and Housing platform via Shelter Cymru or annual events such as gofod3.

3. Exchange information on trends and data to highlight ongoing or emerging issues with service delivery.

Develop a simple system to share analysis of case work and cross reference this with information from the Third Sector sharing trends, evidence and data highlighting problem areas. Benefits include independently sourced evidence and data and lived experiences revealed by front line services. This could be achieved via the points above and also in liaison with the Third Sector Data Unit within Welsh Government.

4. Involve people with lived experience and people working in front line services.

This would help promote holistic approaches to the delivery of public services and encourage regular engagement between public bodies and the Third Sector leading to increased trust and improved service delivery.

5. Increase publicity about the Own Initiative power.

Leading to greater understanding by individuals and organisations who might wish to draw specific service delivery issues to the attention of the Ombudsman.

Acknowledgements

Thank you to representatives of Third Sector organisations who enabled their staff to engage with the project within the required timeframe.

AVOW (County Voluntary Council for Wrexham)

Carers Wales

CAVO (County Voluntary Council for Carmarthen)

Crisis

FLVC (County Voluntary Council for Flintshire)

Learning Disability Wales

Llamau

NEWCIS

Shelter Cymru

TGP Cymru

Thanks are given to the following staff of the office of the Public Services Ombudsman for Wales for the briefings and support given to undertake this project:

The Ombudsman

Chief Legal Adviser & Director of Investigations

Own Initiative Lead Officer

Executive Assistant

ICT support staff

Particular thanks are due to the Head of Policy, Communications and EDI who provided information and technical support.

Appendix 1

Project brief

To gain an understanding of the Own Initiative process and ways of working more generally, as well as with the details of the two Own Initiative investigations to date.

To hold semi-structured interviews with representatives of a selection of Third Sector organisations to discuss views and experiences on the processes, engagement and impact of the two Own Initiative investigations plus any areas for improvement.

The interviews to focus on the organisations working with vulnerable communities directly relevant to the investigations to date.

In addition, to engage with several organisations that have not been closely involved, to gather views on the visibility and understanding of the Own Initiative powers.

To analyse the results and produce a brief report, highlighting in particular any lessons and opportunities for improvement.

Methodology

Familiarisation via reading and briefings

1-1 interviews with:

Shelter Cymru former Head of Campaigns

Shelter Cymru Head of Campaigns

Llamau Chief Executive

Crisis Head of Policy and Communications (Wales)

Carers Wales Senior Policy and Public Affairs Manager

Round table meeting with three County Voluntary Councils, TGP Cymru, NEWCIS, Learning Disability Wales

Analysis and report writing

Appendix 2

List of organisations involved in the project

Organisation name	Type of involvement
Shelter Cymru	1-1 Interviews, recorded and transcribed with 2 people
Llamau	1-1 interview, recorded and transcribed
Crisis	1-1 interview, recorded and transcribed
Carers Wales	1-1 interview, recorded and transcribed
CAVO - CVC for Ceredigion	Round table, recorded and transcribed
AVOW - CVC for Wrexham	Round table, recorded and transcribed
FLVC - CVC for Flintshire	Round table, recorded and transcribed
TGP Cymru	Round table, recorded and transcribed
LDW	Round table, recorded and transcribed
NEWCIS	Round table, recorded and transcribed

Appendix 3

Informed consent form
Qualitative interview participation

Study title: 'Third Sector view of Own Initiative investigations undertaken by the Public Services Ombudsman for Wales'
Researcher(s): Ruth Marks
Institution/organisation: this study has been commissioned by the Public Services Ombudsman for Wales
Contact information: [Insert contact details]

Introduction
You are invited to participate in a qualitative interview as part of a research study conducted by Ruth Marks and commissioned by the Public Services Ombudsman for Wales. Your participation is entirely voluntary, and you may withdraw at any time without providing a reason and without any consequences.

Purpose of the study
The purpose of this study is to gather views of Third Sector organisations in Wales on how the Ombudsman has exercised the power to undertake Own Initiative investigations to date; and whether this power has provided a mechanism to protect those most vulnerable in society.

This research will involve qualitative interviews. The study will be used by the Public Services Ombudsman for Wales to evaluate their Own Initiative work of the office and identify any areas for improvement.

What participation involves
If you agree to participate, you will take part in an interview that will last no longer than 1 hour. The interview will be recorded for accuracy, and your contributions will be analysed to create a report.

Confidentiality and data use

- The interview will be recorded and transcribed.
- Your contributions may be included in the final report, including some verbatim quotes.
- By default, you will be identifiable only by the name of your organisation; your personal name will not be used. While this measure ensures confidentiality, full anonymity cannot be guaranteed due to organisational identification. If you have concerns over your organisation being named, you can choose for that information to be redacted as well.
- The final report will be the property of the Ombudsman, and the Ombudsman may use it in their own publicity and consultation responses.
- All data will be securely stored and used solely for research purposes.
- The transcripts will be retained by the Researcher and kept securely for three months, after which they will be destroyed.

Potential risks and benefits
There are no anticipated risks linked to this study. Your participation will contribute to

the evaluation of the Ombudsman's Own Initiative work and help identify areas for improvement.

Right to withdraw
You have the right to withdraw from the study at any time without providing an explanation. If you choose to withdraw, your data will be removed and not included in the final analysis.

Consent statement
I have read and understood the information provided in this consent form. I voluntarily agree to participate in this research study. I understand that I can withdraw my consent at any time without consequence.

I am / I am not happy to be identifiable by the name of my organisation.

Participant name: ________________________

Organisation name :________________________
Signature: ___________________________
Date: ___________________________

Researcher's signature: ___________________________
Date: ___________________________

If you have any questions or concerns about the study, please contact [Insert Researcher Contact Information].

RESEARCH REPORT

Stakeholder Research

Prepared for:
Public Services Ombudsman for Wales

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This project was carried out in compliance with ISO20252

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Executive summary

Introduction

Beaufort conducted eight in-depth personal interviews with a sample of stakeholders of the Public Services Ombudsman for Wales (PSOW). The eight respondents were recruited from a list of senior stakeholders provided to Beaufort by the PSOW. Interviews break down as follows: three interviews with representative from Local Authorities; three interviews with representatives from Health Boards, and two interviews with representatives from Housing Associations. All stakeholders who took part were Chief Executives or were part of the senior leadership team within the organisation. The depth interviews lasted for around thirty minutes and were carried out online over Microsoft Teams between the 24th February and 20th March 2025.

Key findings

Complaints handling

- Stakeholders interviewed across all sectors expressed a positive perspective on the PSOW's complaints handling, citing its effectiveness, fairness, and timeliness.
- The PSOW's pragmatic and reasonable approach led stakeholders to conclude that the process was efficient, balanced, and beneficial to both the public and the organisations involved.
- There was a high level of trust in the Ombudsman's decision-making and recommendations.
- Implementing recommendations promptly was often noted as one of the main challenges.
- The communication and engagement between the PSOW and public bodies was seen as constructive, fostering a generally collaborative environment for resolving complaints.

Own-initiative investigations and thematic reports

- PSOW's own-initiative investigations were, on the whole, seen as an appropriate and constructive power, particularly in areas lacking regulatory oversight, by providing an external eye on public interest issues.
- Local Authority representatives who had experienced the PSOW's own-initiative investigations had mixed responses, noting both positive and critical aspects.
- The engagement by the PSOW and the overall process was praised by some, but stakeholders sometimes found the experience difficult, time-

consuming and, occasionally, overly critical due to the use of strong terminology like 'maladministration'.

- There were concerns about the clarity of objectives and occasional duplication of regulatory oversight.
- Despite these challenges, the oversight was seen as an opportunity for meaningful service improvements.
- Opinions on the value of thematic reports varied but were on the whole broadly positive. Some praised the insight and oversight they provide on known issues within the sectors.

Complaints handling standards and training support

- Stakeholders reported high levels of engagement and satisfaction with the training provided by the PSOW in this area. The training was felt to help organisations to better adhere to the Complaints Standards as well as improve staff's understanding of the PSOW's processes.
- Introducing the Complaints Handling Standards had led to improvements in organisations' complaints handling according to all stakeholders interviewed across the different sectors.
- However, resource and workload pressures, as well as inconsistencies in complaint recording data, remain key issues.
- Stakeholder suggestions for the future included continuing to offer training and the sharing of approaches to enable consistent handling of complaints. Organisations interviewed expressed the desire for a more cooperative partnership with the PSOW and a collaborative development of new approaches, in addition to limiting bureaucracy as far as possible.
- Stakeholders stressed the importance of the PSOW continuing to foster positive and constructive relationships with them.

Background and methodology

The situation

The office of the Public Services Ombudsman for Wales (PSOW) was established in April 2006 by the PSOW Act 2005. That Act gave the Ombudsman the power to consider complaints about providers of public services in Wales, including:

- local government (such as county and community councils)
- the National Health Service (such as Health Boards, Trusts, GPs and dentists)
- registered social landlords (housing associations)
- Welsh Government and its sponsored bodies.

The Public Service Ombudsman for Wales's main role is to look into complaints about something that has gone wrong with Welsh public services; look into complaints that Welsh councillors have breached their Code of Conduct and ultimately to work with public bodies to improve public services and standards of conduct within local government across Wales.

In May 2019, the Public Services Ombudsman (Wales) Act 2019 gave the organisation new 'proactive' powers to:

- accept complaints other than in writing
- undertake investigations on its own initiative
- establish complaints handling standards for public bodies in Wales
- consider aspects of privately funded healthcare in specific circumstances.

The Act states that, after 5 years from the date of Royal Assent, the Senedd must prepare and publish a report on the operation and effect of the Act. Therefore, The Public Service Ombudsman for Wales commissioned Beaufort Research to explore these topics qualitatively with a small selection of highly senior stakeholders.

Research objectives

The overall objectives for this research were to explore stakeholders' views on:

- the PSOW's handling of complaints including effectiveness, fairness, timeliness and impact
- the challenges of implementing recommendations by the PSOW
- the PSOW's own-initiative investigations and the application of this power
- the value of thematic reports
- the PSOW's complaints handling standards and its impact on organisations
- the training and support offered by the PSOW.

Research method

Given the nature of the objectives, a qualitative research approach was used to allow participants to provide in-depth views on the topics of interest.

The budget available for this project allowed eight interviews with stakeholders to be conducted and analysed. The eight interviews break down as follows: three interviews with representatives from Local Authorities, three interviews with representatives from Health Boards and two interviews with representatives from Housing Associations. All stakeholders who took part were Chief Executives or were part of the senior leadership team within the organisation. The PSOW provided Beaufort Research with a list of senior stakeholder contacts from a range of different organisations, who had agreed to be approached by Beaufort. Beaufort then contacted stakeholders directly via email to invite them to be interviewed at a time and date convenient to them.

The depth interviews were carried out online over Microsoft Teams between the 24th February and 20th March 2025.

It should be noted that the sample for this research was small and was not, by design, representative of all public bodies. However, qualitative investigation is intended to provide in-depth understanding which was required for exploring the research objectives. Its strengths lie in the ability to identify themes, provide illustrative examples of experiences and opinions and indicate the convergence or divergence of views or reported experiences.

The topic guide for stakeholders was developed in partnership with the client (see Appendix). Each depth interview lasted around 30 minutes. The discussions were digitally recorded with participants' consent and transcripts were produced as the basis for the analysis.

An inductive approach to the analysis was used whereby the researcher categorised the data to develop themes that emerged from the content of the interviews. The categories and themes were broadly framed within the key research objectives and topic areas. The analysis of data uses quantifiers (e.g. some, a few) to help determine patterns of opinions among participants. However, these quantifiers should not be generalised and must be interpreted only as applicable to the research sample.

Anonymous verbatim comments made by participants are included in the report. These comments should not be interpreted as defining the views of all. Instead they give insight into individual views on the themes identified. Not all

stakeholders interviewed hold the same opinions which means that the views summarised in the report naturally vary.

Main findings

The Ombudsman's complaints handling and impact of recommendations

Effectiveness
The effectiveness of the PSOW's complaints handling process was acknowledged across sectors, with stakeholders finding it "slick" and appropriately selective. Organisations felt that complaints were proportionately investigated and the rationale for decisions were clear and instructive. The quality of feedback from the PSOW provided clarity for decision-making and learning points for future cases, according to those who took part.

> *There are some intrinsically difficult complaints which the Ombudsman is dealing with, which I think in the main the Ombudsman deals with well. (Local Authority)*
>
> *I think the reports that you get back from the Ombudsman are very good. They put in the rationale, in terms of why they've upheld, why they've partially upheld, why they've not upheld so that it helps us understand the reasoning for the decision and to go back and check against our own decisions. (Health Board)*
>
> *I'm very positive about it. They seem to get the balance right between the things they decide to investigate and those things that they kick back and say go to the landlord and go through their complaints process. (Housing Association)*

A sense of pragmatism and understanding from the PSOW in dealing with complaints was also appreciated by stakeholders across sectors, which contributed to the perception of overall effectiveness.

> *I think we've always had a very sort of mutually cooperative approach... So on the whole they are very pragmatic and very willing to see if the compromise can be reached. (Local Authority)*
>
> *I think when I read the decision letters they are quite pragmatic. Often these cases are quite complex clinical cases that need quite a lot of external specialist input from experts. So I think they go and seek the right expertise*

when they need to, to get an opinion that is going to be useful to them in informing their decisions. (Health Board)

I think the Ombudsman in Wales is very effective. There are patients who are frustrated because they still don't get the answers. I think they are quite pragmatic sometimes because you will get people who are unhappy with the response. But actually it's the essence of the response that has been dealt with appropriately. So I think they are very fair and balanced. (Health Board)

Although the process was considered highly effective, one Local Authority representative commented they wished the public better understood the Ombudsman's role and processes. They believed this would help manage the public's expectations which in turn would minimise the volume of cases the PSOW would have to review. This was a sentiment echoed by other stakeholders.

Fairness

Fairness and balance in complaint handling by the PSOW were unanimously reported, indicating high confidence and trust in the PSOW's work. On the whole, most representatives believed that the Ombudsman understood the constraints within public bodies, leading to reasonable and well-reasoned decisions.

Very fair. They recognise the constraints for local government. Everything is pretty much fair and transparent and no major concerns there. (Local Authority)

I think broadly they are pretty fair. I've not read a decision and thought, "oh, that feels a bit odd that they've made that decision". Where they found issues, I would probably acknowledge that they're right. (Health Board)

Fortunately we haven't had many complaints that have escalated to the Ombudsman, which is really good. And the couple that we've had though, from our perspective, we've always found the Ombudsman intervention to be sort of fair and reasonable and we don't see it as a negative thing to have that external insight and input. (Housing Association)

Even when organisations disagreed with the PSOW's decisions, solutions such as compensation were discussed further and the PSOW provided its rationale for the decision, which was often enough to resolve the disagreement.

Timeliness

On the whole, the PSOW was perceived to handle cases in a timely manner, without unnecessary delays. Stakeholders acknowledged that complex cases took longer but they generally did not attribute these delays to the Ombudsman or believe they were excessive.

> *I'm not aware that we are picking up concerns about the Ombudsman delaying issues... I'm aware of one [case], which is really problematic and probably is not something that lends itself to a swift resolution. But I'm not sensing that there's a shortcoming or shortfall in the Ombudsman's services which are causing delays. (Local Authority)*

> *Pretty good. I think the time frame they work to is pretty much adhered to. So I think it feels that that that process works pretty efficiently. (Health Board)*

> *The ones we've had recently here, I'd say very timely as in it's not dragged on. (Housing Association)*

Some noted that their own organisations' constraints could be the source of delays, especially in terms of resource availability.

> *It's often the criticism that we are not being timely, which I would completely agree with. So I think generally we haven't got any issues with the Ombudsman's time schemes. (Health Board)*

However, one Local Authority representative expressed concern about the PSOW's timeliness regarding Councillor conduct complaints. They believed that prolonged investigations and delayed resolutions could have a potentially negative impact on the Councillor's wellbeing.

In addition, a second Local Authority representative believed the PSOW was sometimes slow in responding to complaints made by the public.

> *When I see the letters come in which tell me they've chosen to investigate or, in a majority of the instances, chosen not to, it tends to be a fairly significant time gap between when the member of the public contacted them and they get that letter saying in the main we're not going to investigate. (Local Authority)*

Impact

The impact of the PSOW's involvement was clear to all, as senior stakeholders explained that recommendations made by the PSOW in the vast majority of

cases led to refined internal practices and responsiveness to feedback. Organisations across sectors said their exact responses varied based on the severity of the issues, with system-wide weaknesses undergoing scrutiny and follow-up reporting. All representatives said the learning from the Ombudsman's recommendations was taken seriously, as changes were embedded into operations. Most stakeholders interviewed could not give specific examples of changes they had made as a result, however.

> *We have been able to refine practices in different ways and we've been able to look at the way in which we communicate and deal with matters internally. And I think it provides a sort of food for thought ultimately for officers by having somebody independent tell them about different ways that they could have done something in a slightly different manner. (Local Authority)*

> *I think it depends on the issue and the severity of the failing, to be honest… If they are system weaknesses with recommendations attached, we make sure they go through the appropriate scrutiny committee. So you know, we attempt to learn from them. [But some] might be individual weaknesses on a part of an individual, rather than systematic failings. (Local Authority)*

> *As an organisation we take learning very seriously. So we will embed the Ombudsman learning into our normal learning processes… I think the learning and improvement is probably the most important part. It can be very useful because it's almost a third eye, isn't it? The Ombudsman is very good at seeing it from the complainant's lens and sometimes helps you to think a little bit differently about the learning and the recommendations. (Health Board)*

> *They've got the advantage of being outside the system looking in. So that's helpful. They've got potentially the advantage of knowing what other organisations do, but there are disadvantages. They're not specialists in the fields they're dealing in, so we may know more than they do about what the resolution should be. But sometimes a critical friend role is helpful. (Housing Association)*

Overall, it was felt the process fostered accountability, learning, and continuous improvement.

> *I think it's fair to say it still carries a fair amount of gravitas. You don't want to be found wanting by the Ombudsman. I think it's got a certain amount of added weight to it as opposed to perhaps by the inspectorate or another agency. (Local Authority)*

Challenges

When asked what, if any, challenges they faced when implementing the PSOW's recommendations, most raised concerns with the prescribed timeframes for implementation. A Health Board representative was disappointed that the PSOW had criticised them for not meeting time scales and had not shown sufficient understanding of their resource limitations or capacity issues.

> *[The challenge] is normally the timeliness of that response in terms of whether we've done it quick enough for the Ombudsman or quick enough for our elected members. And that's often about resources. (Local Authority)*
>
> *We had some changes in capacity in our internal team that were managing Ombudsman inquiries. The Ombudsman felt we weren't reacting quickly enough in responding to their inquiries, and also taking the actions necessary to close down after the event... It did feel a little bit that they weren't being particularly reasonable in understanding some of the capacity issues... Absolutely not saying that we didn't have issues and we needed to get our act together and get the responses done more rapidly. But it didn't feel there was much of a sympathetic ear to some of the issues that we were dealing with. (Health Board)*
>
> *It's always a resource issue, isn't it? What we're already committed to doing in terms of our own corporate plan, service improvement and then there's something that comes from left field... but it's not something we've directly experienced yet. (Housing Association)*

One Health Board said their main challenge was embedding any recommendations across the whole organisation, because any changes needed to be communicated to a high volume of staff working in different sectors.

> *I think we take the learning seriously. I think we seek to embed it as far as possible. I think one of the challenges in the NHS is embedding anything, I mean my organisation's scale is enormous... So communicating with all those people if we make a policy shift or change is not straightforward. (Health Board)*

A Housing Association representative was frustrated that the PSOW could not pass complainants' details to their organisation when the PSOW instructed the

complainants to deal directly with the Housing Association. They understood the data protection constraints, but felt it was a missed opportunity that the PSOW did not obtain complainants' permission to pass their details on so they could resolve the issues more speedily.

Relationship Management

All stakeholders described their relationship with the PSOW as positive and collaborative on the whole. They stressed the importance of having open and frank discussions with the PSOW in order for them to be constructive, effective and allowing for the mutual resolution of cases.

> *But overall the whole relationships have been positive. No issues of any major concern in the context of how complaints are dealt with. (Local Authority)*

> *Generally when we deal with some really tricky cases, I really value the ability to say, well, I want you to go to the Ombudsman. So I think it demonstrates a level of confidence in them as an independent body. (Health Board)*

A Local Authority representative believed their relationship with the Ombudsman had improved since their organisation enhanced their own complaints handling.

> *One of my reflections is the importance of the Council itself having in place effective corporate complaints handling arrangements. So we took steps several years ago to strengthen our complaint handling and as a consequence I think our engagement with the Ombudsman is better. (Local Authority)*

Two representatives attributed their more effective relationship with the PSOW to their positive personal relationship with the incumbent Ombudsman. Similarly, one Local Authority representative was 'struck' by the current Ombudsman's willingness to deal with an issue personally, which was appreciated.

> *The current Ombudsman has sought to develop more effective relationships with the health board leaders because I think we do constitute a lot of their work. I could communicate directly with her. She has connected directly with me. And that's very helpful. And we meet at least once a year to have a proper conversation about how things are going and what her observations of where the opportunities are for us to improve. I think that's extremely useful. And I really welcome that. (Health Board)*

I've been quite struck by the refreshing willingness of the current Ombudsman to engage personally with an issue if it's appropriate.... And therefore, the Ombudsman is sort of open to having a conversation. And I think that's really helpful. (Local Authority)

The Ombudsman's use of own-initiative investigations and thematic reports

General views on PSOW's own-initiative powers

Own-initiative investigations were, on the whole, seen as an appropriate and constructive power, particularly in areas lacking regulatory oversight, by providing an external eye on public interest issues.

I think it's good, I think it's important that they have that level of autonomy and that they have statutory backing to undertake those investigations. I think I've only seen one, possibly two since I've been here where they've instituted the publication piece where they, you know, make it public. (Health Board)

I think for example, damp and mould and fire safety. It is well known in the press and media that the housing sectors perform poorly for tenants [on these issues] and it'll be very reasonable for the Ombudsman to decide to investigate those in a bit more depth. (Housing Association)

Stakeholders across sectors strongly believed the PSOW should collaborate with public sector bodies when conducting own-initiative investigations to ensure a constructive approach. One representative from a Housing Association believed it was appropriate for the Ombudsman to investigate issues but that good practice guides needed to come from inside the sector itself given the requirement for sector-specific expertise.

I think it would be useful for the Ombudsman to liaise with like our sector body, like Community Housing Cymru, say, if they pick up an issue so that it's done collaboratively rather than the Ombudsman goes away and then comes back to the sector. This is where you go wrong... I would want it to be done in partnership. So it would be like actually we recognise that's an issue as well. So we're working with the Ombudsman to try and improve rather than we're being investigated. (Housing Association)

I think there is a danger in people with a policy background writing good practice guides when they haven't actually done it themselves. You know, they really do need to come from a background where they've done it at the front line. (Housing Association)

Nevertheless, stakeholders across all sectors warned that the PSOW's own-initiative investigations could risk duplicating work that had already been carried out by other agencies such as Audit Wales, Welsh Government, Health Inspectorate Wales, Care Commission Wales and other regulatory agencies that reviewed organisations' activities and produced reports sharing good practice.

I guess in our world obviously there's already quite a lot of people who can come and look into our services. You know, we have Health Care Inspectorate, we have Welsh Government, we have various speciality, you know, royal colleges.... My nervousness would be how do we make sure that the Ombudsman isn't doing something that is already being done by somebody else or replicating or duplicating work because there's no shortage of recommendations about. (Health Board)

I think hopefully everyone can learn from having gone through these two processes. I think it's still probably at the very early days of this process. Then the next one, I think I would just suggest looking perhaps at an area where there is no overarching regulator overseeing it. (Local Authority)

In addition, stakeholders stressed the importance of having clear objectives and an evidence base to explain the PSOW's rationale for the need to focus on the topics and organisations it chose to investigate.

Sometimes my experience of Ombudsman generally, is that they will pick up a sort of an independent review because of political noise for example, or because a patient is very loud in their criticism. And I know this has happened in England. I think the Ombudsman has to be proportionate and they have to make sure that in exercising that power they are proportionate... I think sometimes the political nature of things will drive an investigation, not necessarily the evidence base. That's more of my experience from England, but I think there's a risk in Wales of that. (Health Board)

Experience of the PSOW's own-initiative investigation

Local Authority representatives with direct experience of PSOW's own-initiative investigations in the past had mixed responses to the process, noting both positive and critical aspects.

Positively, two Local Authority representatives believed the own-initiative investigation process had been handled well by PSOW, as it was clear and their Councils had been given the right to comment on the first draft.

> *I think it's appropriate and I think the Ombudsman is finding the right balance and he's not exercising those responsibilities in a way which might be considered to be overbearing and adding to resource pressures. (Local Authority)*

> *I think the way they went about doing it was quite positive. They engaged with people at the start of the process. They gave an idea of terms of reference. They gathered all the information that ultimately was needed. They gave an opportunity to comment on the draft. So from a process perspective, no major issues at all. (Local Authority)*

Less positively, one Local Authority representative found the experience 'tricky' and 'time-consuming'. They did not believe the PSOW had clear aims at the start of the process, which led to it being laborious and taking longer than needed.

> *I don't think they were clear on what they were trying to achieve when they went into it. We had lots of meetings with them around sort of terms of reference, representations, time frames. The thing ended up taking 18 months plus to bring to a conclusion… by the time they got to the end of it, a lot of the impetus had been lost. We were sort of almost beginning to make improvements because we were aware of what their concerns were as we were going through the process. (Local Authority)*

Moreover, two Local Authority stakeholders interviewed felt the PSOW investigation had been overly critical and too ready to use terminology like 'maladministration', which they believed was misleading and not an accurate reflection of the service as a whole. According to these stakeholders, when these concerns were raised with the PSOW, the initial response from PSOW staff had been 'quite defensive'. These Local Authorities did not believe the PSOW fully appreciated at the time the consequences of using such terminology, but were grateful that the PSOW subsequently agreed to review the language used as part of the process.

> *I think the initial finding was one of maladministration, which quite frankly would have opened us up to all kinds of litigation and concerns. And it was almost like they didn't quite understand the consequences of that recommendation. I'm not sitting here saying our care services were perfect*

and couldn't be improved. I'm not saying that at all. We knew when they picked it that we'd be found wanting in some respects. So we were, we were ready for that. (Local Authority)

Furthermore, some highlighted inconsistencies and 'mixed messages' arising from different investigations conducted by different regulators. For example, sector regulators such as Care Inspectorate Wales were said to have approved Local Authorities' health and social care services whilst the PSOW in its investigation had described the services provided as 'maladministration'. Some of the Local Authority representatives therefore concluded it would be beneficial for the PSOW to use its own-initiative investigation powers to plug any gaps, rather than go over the same ground.

I think the other element that I picked up on is there are lots of statutory regulators in the background in respect of that particular area of work, like Care Inspectorate Wales and other national associations. Here you had Care Inspectorate Wales saying the service was functioning, it was meeting all the various standards and the Ombudsman was saying no, there was maladministration. So I think one of the things that I sort of took away from it is it what would be really helpful if the Ombudsman picked areas in which there are no sort of regulators, there are no other organisations. (Local Authority)

There were recommendations that came out that were contrary to recommendations that we'd previously had from Care Inspectorate Wales.... That's a pretty invidious position to find yourself in. (Local Authority)

One Local Authority representative also questioned whether the PSOW was clear as to whether the recommendations at the end of the review were mandatory or good practice recommendations. They did not believe the recommendations should be mandatory for the four Local Authorities that were investigated if these same recommendations were not mandatory for the other eighteen Local Authorities that were not involved.

Despite these challenges, the oversight was seen as an opportunity for meaningful service improvements. There was a desire for the PSOW to frame their own-initiative investigations as a means to aid service improvement rather than criticism.

I always understood own-initiative investigations ultimately to be to look at areas of practice and how can we make them better, not criticise people for not doing things. And you know, we have taken on board those and we are

now looking to implement them as part of our service review. (Local Authority)

Value of thematic reports

Opinions on the value of thematic reports varied but were on the whole broadly positive. Some praised the insight and oversight they provide on known issues within the sectors e.g. accessibility in public services and damp and mould in the social housing sector.

> *They've got intrinsic value, I think, because of the insight that the Ombudsman can bring to a particular set of issues. And you know, what's been focused on here are some vital issues in relation to access, concerns by members of the public about levels of accessibility and communications... Absolutely drawing together some of these concerns into these thematic reports can improve service delivery. The Ombudsman is in a pretty unique position to shine a light. (Local Authority)*

> *So we will go through a process of sending those reports out. We'll ask for a response from our operational teams or our central teams on the content and we'll make sure that that's built into our improvement programmes. So they're, you know, they're very helpful in terms of reflecting on the evidence base, reflecting on the experience of people, the safety of people and then putting in place the improvements. So there again, they're another key arm of our assurance framework. (Health Board)*

> *[Living in Disrepair report] was quite sort of high profile and came out at a good point in time when we were looking to improve and change. We just shared it with our senior leadership team. I think we then took it to our resident panel with a supporting document and then used that alongside some others .. to come up with an internal action plan. (Housing Association)*

However, a Health Board representative felt the thematic reports risked adding to the 'white noise' of existing reviews. One Local Authority representative did not recall seeing any thematic reports that focused on Local Authority issues specifically so believed more relevant thematic reports were needed for them to be more impactful in their organisation. Stakeholders acknowledged that the PSOW had a valuable and different perspective on issues so a few believed it would be important to highlight this added value in order to differentiate their reports from similar documents on the topics.

> *So I suppose at this stage maybe they're not given the attention probably within the wider networks of the Council. So, for example, I read them when they come in and you look at the different issues and what they're suggesting*

but there hasn't been anything that Local Authorities can take some tangible benefits from at the moment. It would be good to see more focus on local government issues and some of the day-to-day elements so people can then look to see how they're going to implement them. And they can be seen, as, you know, opportunities of good practice across the board. (Local Authority)

I guess it's about being clear what's the purpose of doing a thematic report. If we take the top topic of hospital discharge, there must have been four or five different bodies that have done reviews on hospital discharge across Wales. And there is a danger then that it becomes almost like white noise a bit and people don't even spend the time to read it because they think it will just say the same things the other people said but in a slightly different format. (Health Board)

One Housing Association representative, who used resources provided by the English Housing Ombudsman, was not aware of any thematic reports produced by the PSOW relating to their sector. They did, however, express an interest in receiving more general information from the PSOW, recognising the potential relevance of its recommendations across different sectors.

I haven't been very conscious of the sort of bigger picture around their work on local governments and health service... It'd be quite good to get a bit more from them in terms of communication with me as Chief Executive around, you know, public services. What are the issues coming up? Because the way we handle stuff or don't handle stuff is not that different from local government or the health service really. It's all about communication and systems and processes and how well people are trained and all those sorts of things. (Housing Association)

The Ombudsman’s role in setting complaints standards and training support

Complaints standards and improvement

Overall, the PSOW’S Complaints Standards were welcomed by all organisations interviewed across all sectors. Some stakeholders felt the Complaints Standards and the PSOW’s support had helped organisations make significant improvements in complaints handling processes. The improvements mentioned included ensuring corporate visibility, coordinating complex complaints, and revising internal processes to align with established frameworks.

> *About X years ago, we were stung by Ombudsman feedback about the way in which particular areas of the council dealt with specific cases. It absolutely highlighted the need to get a much better grip of the way in which the council was dealing with complaints. And that's what we did. We've improved our handling of complaints significantly since then. (Local Authority)*

> *The conversations we've had with the Ombudsman I think gave us a clear focus about how we handle those complaints that do go into Ombudsman, how do we make sure that they are as effective as possible? But also how do we make sure our overall process for all complaints and concerns is as inclusive and easy for people to use as possible so that we try and minimise the sort of numbers that will end up going into an Ombudsman process. (Health Board)*

> *So we had a two stage process already and it wasn't massive changes, it was tweaks to the policy rather than anything fundamental. So that was fine. (Housing Association)*

For some, the adoption of Complaint Standards had facilitated a clearer focus on complaint handling and encouraged proactive use of the Ombudsman's resources.

> *I think it's made it visible ultimately that there are different rules and processes. So when we've had the opportunity to be able to revise and review our internal processes, we've always got a framework now ultimately in which to measure it against to ensure that we're meeting those requirements at the same time. So yes, naturally it has. (Local Authority)*

There's really good communication between the Ombudsman and organisations and for us to make the most of that relationship as well, not wait for the Ombudsman to knock on our door, be more proactive. I think we need to do that, which I do think the Complaints Standards has helped. (Housing Association)

Challenges

Although stakeholders were positive about the PSOW's Complaints Standards, most did experience some challenges with meeting the PSOW's requirements in practice. The main challenges cited were resource and workload pressures, notably the lack of dedicated complaints officers for some smaller organisations and the additional demands from the PSOW.

It's just resource implications ultimately on local government because as a Council, we do not have any dedicated complaints officers whose sole role it is to actually [deal with] complaints... So obviously the more requirements that ultimately factor in from the PSOW, the more resource heavy it becomes ultimately on officers to be able to take forward. So that's really the only point. (Local Authority)

It's usually resource challenges in terms of, you know, what sort of prominence precedent you give that, compared to the other issues you're dealing with at a given time. (Local Authority)

Local Authorities who were sometimes struggling with resource were grateful to the PSOW for their understanding when the Council notified the PSOW that they would be late submitting their response.

Health Board representatives also commented on the 'challenging' timescales set by the PSOW as a constraint, but it was acknowledged that it was important not to overextend the complaints process. However, one Health Board representative felt the PSOW put too much emphasis on a quick resolution and meeting timescales. They believed it was important to bear in mind the complex nature of the complaints in their sector in particular. They strongly believed the emphasis should always be on arriving at the correct outcome for the complainant rather than on the speed of the resolution.

It's just perhaps appreciating the environment in which we're operating in. Some of these areas are always quite complex and do require coordination of

lots of different bits of information, which can often take a bit of time to get. And sometimes there may be a perception, I think, that people don't quite appreciate that sometimes it's not all just about getting it through in the timeline. Actually, it's better to get the right people to review the complaint because if we're going to make any learning, they've got to be part of that process. (Health Board)

Representatives from Housing Associations mentioned difficulties in standardising complaints recording across the sector, thereby impacting the reporting of complaint rates. Both Housing Association representatives were concerned about the possible reputational damage inflicted by data published in the future on complaints levels which were not measured in a standard way across the sector.

We can't publish data which is measuring apples and pears, which is what will happen again in the summer if they don't insist that people will do it the same way. (Housing Association)

It is helpful to be in line with everybody else in terms of the way that we're handling complaints. I think [recent events] highlighted this kind of issue. It's probably an issue for our organisation and making sure we capture that informal complaint resolution as formal complaints...So that probably this is something we're a little bit nervous about at the moment because we haven't reached a consensus as a sector on what the Ombudsman is looking for from us and when, what they want to do with that data and for what purpose. (Housing Association)

Training and engagement

There was overall satisfaction evident with the current training provided by the PSOW, with almost all organisations interviewed having taken up the offer of training. Stakeholders believed the PSOW proactively offering to provide training had helped to foster good relationships between organisations and the Ombudsman. In addition, stakeholders believed it was beneficial for organisations to help align their approaches with the standards and that the training helped to improve staff's understanding of the process and of the PSOW's requirements.

I think it's been good, and I think we've had some good support. As I said, when we were going through a bit of a transition, I know that our team were working very proactively with the Ombudsman's case team to try and make

sure that we all were on the same page and working to the same standard. So I think that's worked well. (Health Board)

My team have attended the training. As I say, my complaints team have a very good relationship with the Ombudsman. They meet with her regularly. We've certainly drawn the training into the organisation. I've had no concerns raised about the training. In fact, it's been a positive aspect of the development of our team. (Health Board)

We had a big batch of training probably about six months ago now and we've just reached out recently. So part of us looking at trying to improve again is to get some more training, repeat for some people, new for people who have joined the organisation. So yeah, the training was good.... The training has been a step in the right direction in breaking down barriers and fears about the Ombudsman. (Housing Association)

In addition, some stakeholders believed the training included useful materials and was accessible, which contributed to their team's development. Although positive overall, one Local Authority representative believed it would be beneficial if the training could be tailored to the organisation's needs and be more focused, so that staff could benefit fully.

There was material, shared sense of good, bad letters. It was, you know, easy to understand and engage with no issues at all with that. And it's good that we can just say actually we'd like some more free training please. (Housing Association)

On the whole, the training is very good, a good relationship. It would be beneficial to see in some cases if it can be made a little bit more bespoke to the issues individual authorities are dealing with. (Local Authority)

Most stakeholders could not think of any additional training needs or did not believe they were best placed to answer this question. However, a few participants had suggestions for additional training they felt could be beneficial for their organisation. One Local Authority representative believed additional training would be beneficial for staff in more senior roles, while another Local Authority representative wanted those who were involved in the complaints process to better grasp the Ombudsman's handling of conduct-related complaints. Also one Health Board representative suggested targeting training towards GP practices to align improvements specified by the Ombudsman with their practices.

Considerations for the future
Continuing to have open communication and engagement with the PSOW were thought to be important by representatives across the sectors. Stakeholder suggestions included continuing to offer training and the sharing of approaches to enable consistent handling of complaints. Organisations expressed the desire for a more cooperative partnership with the PSOW and a collaborative development of new approaches, in addition to limiting bureaucracy as far as possible.

> *The Ombudsman continuing to engage positively with stakeholders is important. … Having good levels of discussion and conversation with the authorities themselves. So that they're not operating, you know, there's a bit of a no surprises approach, which is important. So, yeah, there's fundamentals here which need to continue I think. (Local Authority)*

> *Overall we have a really positive relationship, … hopefully we can develop further and I think it's if we can work in more partnership. We're all coming at this from the same aim from a complaints perspective; we want to reduce the number of campaigns to make sure there are improvements ultimately in the system. So if we can find that way to gel together that little bit more and find ways where we can share good practice. So instead of it being the Ombudsman comes up with a new approach, could they work with Local Authorities… So yeah, more collaboration I think would be a very useful approach. (Local Authority)*

> *By definition it's a bureaucratic process, but we don't want it to be unnecessarily bureaucratic. (Local Authority)*

> *A sort of a collaborative approach to it, basically. Yes, of course they've got statutory responsibility, but the best outcomes can be achieved if you work together to try and get a better outcome for the individual if they've gone to the Ombudsman. (Health Board)*

One Local Authority representative was concerned about the volume of complaints increasing due to service cuts in the local area. They believed the PSOW should be aware that the narrowing of eligibility criteria for certain public services would cause the number of complaints to increase and that this would likely, in turn, have a knock-on effect on the number of complaints made by the public to the PSOW.

Appendix

Public Services Ombudsman for Wales
Stakeholders topic guide FINAL

The main areas of interest are views on the Ombudsman's:

- complaints handling and the impact of recommendations
- use of own-initiative investigations and thematic reports
- role in setting complaints standards and the training and support offered by the Ombudsman.

A. Introduction (5 mins)

1. *Thank participant for helping out. Introduce self and Beaufort as an independent company.*

2. *Explain aims of discussion:* The Public Services Ombudsman for Wales wishes to gather insights on the quality of own services and impact, with particular focus on the office's power to undertake own-initiative investigations and promote good complaints handling.

   The Ombudsman intends to use any insights from this research to inform response to the ongoing review of the office by the Senedd's Finance Committee and to identify opportunities to improve services.

   As we said in the email invitation, these discussions are confidential. We follow the Market Research Society Code of Conduct which means among other things that we look after the data we collect and aim to preserve your anonymity. Just a quick reminder:

   - The Public Service Ombudsman gave us a shortlist of stakeholders they wanted to hear from, and we've selected participants from that list. So, they'll know who we're approaching but when we report back, we won't attribute comments to individuals or name organisations. However, we will attribute comments and points raised by type of organisation e.g. health board, local authority or housing association.
   - During the conversation you can flag if there is any feedback that may need careful wording to ensure anonymity, as far as possible.
   - The process is entirely voluntary.

- I'd like to digitally record our discussion. This is for Beaufort's analysis. We don't share it with the Ombudsman. Afterwards, we'll make a transcript for analysis. Any questions?

3. Now the **recording has started**, can I check that you're still happy to continue?

B. The Ombudsman's complaints handling and impact of recommendations (10 mins)

Overall perceptions for context

4. What are your views on how the Ombudsman handles complaints about your organisation? *Probe including*
    - How effective were they when dealing with the complaints?
    - How fair were they with your organisation?
    - How timely were they when dealing with the complaints?

5. When the Ombudsman upholds a complaint, **what impact** do the recommendations have on your organisation? *Probe for examples of* improved service user satisfaction / service improvements

6. What, if any, **challenges** have you come across in implementing the recommendations received from the Ombudsman?

C. The Ombudsman's use of own-initiative investigations and thematic reports (10 mins)

Moving on to focus specifically on the Ombudsman's systemic work, such as use of own-initiative investigations and thematic reports.

Ask any remaining organisations

7. The Ombudsman has the power to investigate an issue even when they have not received a complaint. What are your thoughts on this?

8. Do you believe that the Ombudsman is using this power effectively, or could it be improved?

9. And what impact, if any, do the Ombudsman's thematic reports have on improving your services?

10. Is there more that the Ombudsman could be doing to promote systemic improvement of public services?

D. The Ombudsman's role in setting complaints standards and training and support (5 mins)

11. How would you rate **the training and support** offered by the Ombudsman to your organisation to improve complaints handling?
Probe:
    - What additional training or support would be useful?

12. Has the Ombudsman's complaints standards work **led to improvements** in how your organisation handles complaints?
For example are there any improvements in:
    - Data collection practices?
    - Reporting?
    - Experiences for service users?

13. What are the **challenges**, if any, in complying with the Ombudsman's complaints standards?

14. What would help your organisation to further **improve** how it handles complaints?

D. Wrap up (2 mins)

15. Before we finish is there anything else you'd like to add that would be useful for Public Services Ombudsman for Wales to know?

Thank and close