

National Assembly for Wales
Equality, Local Government and Communities Committee
7 December 2017
Evidence in support of the Public Services Ombudsman (Wales) Bill

1. Introduction

- 1.1 The legislation governing my office is the Public Services Ombudsman (Wales) Act 2005 (PSOW Act 2005). At the time it was enacted, it was at the cutting edge of Ombudsman legislation¹ and is still highly regarded in the UK and internationally².
- 1.2 I am pleased that the Assembly's Finance Committee has introduced the Public Services Ombudsman (Wales) Bill and that in addition to my current powers (as contained in the 2005 Act) the Bill has also proposed new powers.
- 1.3 The changes set out in this paper, and included in the Bill, reflect four underlying priorities:
- a) **Future proofing:** the proposals are intended to ensure that the legislation continues to be fit for purpose, but that it also addresses future challenges which will affect service users in an ageing society where there are greater levels of physical and emotional vulnerability.
 - b) **Social justice:** the proposals seek to ensure that citizens from more deprived backgrounds, who may be more reliant on public services, will find it easier to make a complaint.
 - c) **Citizen Centred:** the proposals would strengthen the citizen's voice and ensure that wherever possible processes follow the citizen rather than the sector or the silo.
 - d) **Drive complaint handling and public service improvement:** these proposals will make a real contribution to public service improvement and reform whilst offering excellent value for money. The changes can be achieved whilst maintaining the Public Services Ombudsman for Wales (PSOW) budget at no more than 0.03% of the Welsh block budget.

¹ Ombudsman Legislation – time for a review? Peter Tyndall, March 2013

² Law Commission: Public Services Ombudsman – July 2011

2. Areas for change

2.1 Own Initiative Investigations

- a) Almost without exception, public services Ombudsman schemes throughout Europe, and indeed internationally, have own initiative powers, allowing them to investigate an area of concern without having first received a complaint about all aspects to be investigated. The Ombudsman in the Republic of Ireland and the Northern Ireland Public Services Ombudsman also have such a power and in Scotland the Ombudsman is now seeking this power.
- b) The power is used sparingly and only with good reason. (Between 2001 and 2010 the Ombudsman in the Republic of Ireland undertook just five own initiative investigations.)
- c) This power is likely to become more important as we see the impact of an ageing society with citizens in vulnerable positions, either unable or too afraid to complain.
- d) Own initiative investigations would be considered in the following circumstances:
 - i. Where a failure brought to my attention in one organisation appears likely to affect other people because it is systemic within the organisation and/or may exist in other bodies. The new power would allow my office to look proactively to see whether this is the case. For example:

Example 1

Looked after Children are often vulnerable young people who need the best support that they can be given. A complaint from one Looked after Child in one local authority identified an unexplained loss of savings whilst in foster care. Failings on the part of the local authority meant that the Looked after Child did not have the savings when leaving care that he had expected. He also had no explanation about how his savings had been used or where they had gone.

My investigations suggested that there were unclear processes and responsibilities, together with an absence of meaningful oversight of savings by the local authority. The nature of the failings suggested that it was likely that other Looked after Children in that local authority were affected and, since the adequacy of national guidance was brought into question, that Looked after Children across Wales might be similarly affected.

The current limitations meant that I could address the issues only for the one Looked after Child who submitted a complaint. Whilst I could make recommendations to the local authority involved and publicise

the issue through the publication of my report, I could only hope that this might help secure improvement across Wales.

Example 2

I recently received a complaint that there had been a lengthy delay before an ambulance could attend to a person who had been injured at home. The cause of the delay appeared to be as a result of ambulances being tied up at a hospital. There was no complaint against the relevant Health Board because there had been no direct service provided between the complainant the hospital concerned and the complainant had had no direct contact with the relevant Health Board.

If I were to have the power to start an own initiative investigation I would, in future, be able to investigate both bodies in order to investigate the circumstances as a whole. Depending on the outcome of such an investigation there may also have been an opportunity to consider whether there were any general wider learning points across Wales.

- ii. Where I receive an anonymous complaint and the issues raised appear sufficiently serious to warrant an investigation.
- iii. Where I am made aware of a problem about service delivery across the whole, or part, of a sector of the public service in Wales but no direct complaint has come forward, perhaps because the persons affected are too vulnerable or concerned about the repercussions. Investigations of this type would need a sound basis and rationale to protect the Ombudsman's reputation, as pursuing high profile investigations without firm evidence could pose reputational risk.
- iv. To extend an investigation into a complaint to other bodies where it appears that the maladministration or service failure identified involves an organisation other than the one initially complained about. For example, an ongoing investigation of a complaint against a GP could reveal information about a related matter involving a local health board. There may be evidence of a systemic problem at the Health Board which is beyond the control of the GP complained about or the complainant may not be aware that any service failure was in fact the fault of the local health board as opposed to the GP they have complained about.

Example 3

My office considered a complaint made by a daughter who complained that her mother's GP had failed to ensure that aspirin, which had previously been prescribed for atrial fibrillation, was reinstated following a period when it had been stopped because she was taking other medication.

It became apparent that the investigation had to be broadened out to include the actions of Health Board professionals, after my Advisers expressed concerns about the failure of the GP to consider prescribing warfarin, rather than aspirin, for atrial fibrillation, and the failure of secondary care professionals in the Health Board to alert the GP to consider this.

The complainant had to then submit a fresh complaint so that I was able to investigate the Health Board's actions in addition to the GP practice.

I upheld both the original complaint against the GP and the complaint against the Health Board. I also recommended that both organisations make financial redress payments to the complainant in recognition of distress caused by the failures identified and that procedures be reviewed to ensure that a medication review is carried out in the relevant hospital before a patient on warfarin is discharged and communication in correspondence between clinicians and GPs are explicit and clear.

If new powers are enacted, in the future I would not have to ask the complainant to submit a fresh complaint, making it a less bureaucratic system for the complainant, and saving time and resource within my office.

2.2 Oral Complaints

- a) The current legislation requires for all complaints to be made in writing. Whilst I have discretion to accept a complaint in another form if appropriate, this must be considered on a case by case basis.
- b) A key point that has been reinforced by several people, and the Law Commission, is that this requirement could be at odds with Equality legislation. It is certainly a barrier in relation to the first of my office's values 'Equality and Fairness'. Allowing complaints only in writing is potentially excluding people who find it difficult to write, for example people with learning disabilities. In Wales, only 87% of the population attain literacy level 1 or above (compared with 94% in the UK)³. My services should be accessible to all and not dependent upon my exercising discretion to accept a complaint. Also there are instances when my staff exercise my discretion and complete forms for complaints over the telephone but these are not signed and returned to my office. Recent examples of this include the following cases:

Example 4

A complaint concerning the failure of a local authority to provide support to a child with difficulties in schooling and also the alleged failure of a health board to provide appropriate care and treatment to the child.

³ Welsh Government Social Research: National Survey of Adult Skills in Wales 2010

Example 5

A complaint alleging that a council's social services department failed to carry out a Community Care Assessment.

Example 6

A complaint alleging that a GP practice had failed to diagnose a lung condition.

- c) Increasingly Ombudsman schemes are taking a human rights-based approach to the way they consider and investigate complaints. Whilst implicit in the way we work, this year has seen my office give more detailed consideration to the way we work from this perspective. Fundamental to a human rights approach is provision for the right of speech, and other communication methods, to convey a grievance.

2.3 Complaints Standards Authority (CSA)

- a) The overall aim of the CSA is to improve complaints handling to ensure that complaints are handled more simply, more effectively and more consistently, and are resolved at the first point of contact, wherever possible. In Scotland, the CSA role has been particularly effective in allowing the Scottish Ombudsman to tackle problems in the standards of complaint handling within the bodies in its jurisdiction. Whilst we have developed a model complaints policy to help encourage consistency across public service providers in Wales, take-up has been patchy in some sectors, and under current arrangements there are no powers to address this. I believe that there is a strong case for adopting a CSA approach so that any guidance given to bodies on complaints handling has statutory force so that I can help support improvement in public sector complaints handling.
- b) Data collection and the reporting on complaints to management/ Cabinet/scrutiny committees also vary widely. Not all IT systems in local authorities are fit for purpose in relation to data collection, and in some cases manual recordings/adjustments are being made. The approaches to data collection and what is being captured also varies amongst them. It should be said that since no-one collects this data at an all-Wales level, there is no real motivation (or indeed external pressure) to encourage change/improvement in this regard.
- c) A statutory power to tackle these issues would address this 'patchy' approach to complaints handling reporting. Consistency would then enable comparisons at an all-Wales level and contribute to an understanding of areas where service delivery in Wales may not be what it should be. Consistent data would allow for these to be explored by relevant parties, such as the sector itself and the Welsh Government.
- d) With the proposed local government reforms in Wales, now is a perfect time to introduce this power in line with these changes, and ensure that further collaborative arrangements do not become more complicated from the citizen's

perspective. Accountability should always be clear to the service user where bodies collaborate on the delivery of services.

2.4 Private Healthcare

- a) With an ageing society, integration of health and social care is an important part of public policy. In 2014, my jurisdiction was extended to include self-funded social care. However, I currently cannot investigate private healthcare unless it was commissioned by the NHS. The circumstances where I would want the discretion to consider complaints about private healthcare would be where a person's healthcare pathway has involved NHS treatment and private healthcare, for example where care has been delivered both by an NHS GP or clinician, and an 'independent hospital' or the private practice of health professionals conducted on NHS premises.
- b) I am of the view that there is public interest in being able to investigate 'the whole of a complaint' made to me where there has been treatment by public and private providers to allow me to identify where something may have gone wrong. The complaint should follow the citizen and not the sector.

Example 7

In one case that I could not resolve, a patient had been treated by the NHS, then privately (self funded) and then again in the NHS. The patient sadly died. I was unable to investigate the private funded healthcare.

Although this issue does not arise in many cases it does have a significant impact for the individual concerned when it does arise because they are not able to receive full answers to their concerns about care which has involved both NHS and private healthcare.

3. Comments

- 3.1 Schedule 3 - I do not believe that it is necessary to include the Wales Audit Office (WAO) in the revised schedule 3 of the Act. I agree with the Auditor General that the inclusion of the WAO within my jurisdiction risks causing confusion for individuals who may erroneously consider that I could review audits undertaken by the Auditor General. The WAO's functions are limited to providing resources to and monitoring and advising, the Auditor General, therefore I agree with the Auditor General that it is hard to see how I could be presented with a case that would warrant investigation.
- 3.2 Whilst the criteria for own initiative investigations as outlined in sections 4 & 5 and 44 & 45 of the Draft Bill would, if enacted, empower me to undertake the "Wider investigations" outlined in i,ii,and iii above it is not clear whether the criteria would also empower me to undertake all of the possible "Extended investigations" outlined in iv above. For example, where systemic issues may not be apparent but the complainant has not complained about a particular body because they are not aware of the full facts.

- 3.3 Section 33 of PSOW Act 2005 appears to have been omitted from the Bill. This is an important provision because it places a duty upon public bodies to inform complainants of their right to approach my office. Whilst I could include similar requirements in any complaint handling procedures I issue under Part 4 of the Bill, I believe that having the direct duty placed upon public bodies on the face of the 2005 Act has had a positive impact.
- 3.4 Section 64 - the Northern Ireland Public Services Ombudsman and the Prisons & Probation Ombudsman are not listed.

4. Conclusions

- 4.1 The Public Services Ombudsman (Wales) Bill will future proof my legislation, be more citizen-centred and help drive better complaint handling and service improvement and, ultimately, social justice.

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