Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

The Annual Report 2004/05

of

The Commissioner for Local Government in Wales
The Welsh Administration Ombudsman
The Health Service Commissioner for Wales





Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

The Annual Report 2004/05

of

The Commissioner for Local Government in Wales
The Welsh Administration Ombudsman
The Health Service Commissioner for Wales

Laid before the National Assembly for Wales
under Paragraph 6 of Schedule 9 and Paragraph 7 of Schedule 10
to the Government of Wales Act 1998 on 26 October 2005

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

Contents

1 Introduction

During 2004-5 substantial progress was made towards the creation of a unified ombudsman service for Wales. Although I continued to hold the separate offices of Local Government Ombudsman and Health Service Ombudsman for Wales, and was appointed in November 2004 to the further office of Welsh Administration Ombudsman, it seems appropriate to bring the various Annual Reports together in an omnibus volume for the first time.

By far the most important development was the passage of the Public Services Ombudsman (Wales) Act 2005. The Bill, having been introduced in the House of Lords, was considered by a joint Committee of the House of Commons and the National Assembly for Wales, to which I gave evidence. It received all-party support both in Parliament and the Assembly. I am delighted that the Act provides not only for the unification of the Ombudsman offices serving the people of Wales, but also provides a modernised and streamlined legislative framework within which the new service will be able to operate. The Act will be brought into force by an Order made by the National Assembly – which may well have been passed by the time this report is published, although I do not expect the main provisions of the Act to be commenced before 1 April 2006.

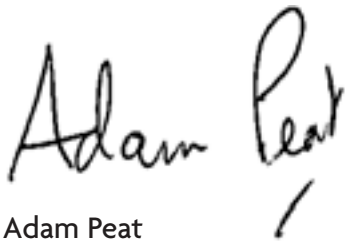
Throughout 2004-5 I continued to have two distinct groups of staff – the staff of the Commission for Local Administration, in Bridgend, and the staff of the Health Service Commissioner for Wales, in Cardiff (the latter group also dealing with Welsh Administration Ombudsman matters). In consultation with staff and their unions, a new unified staffing structure was drawn up, and a procedure for matching individual members of staff to posts in the new structure was agreed. This took place in tandem with planning for both groups of staff to move to new office premises on the

outskirts of Bridgend near the Pencoed motorway junction. That move took place in March 2005, enabling the new staffing structure to be put into effect. Throughout 2005-6, therefore, staff will operate as a unified team in anticipation of the PSOW Act coming into force.

March 2005 also saw the introduction, after months of planning and staff training, of new common operating procedures, underpinned by the introduction of a new IT system and computerised case management system. Despite the planning, there were initial teething problems with the new IT system and this together with the disruption caused by the office move contributed to a backlog of cases building up at the year-end. I shall be concerned to overcome this during 2005-6 and to ensure that cases are dealt with within a reasonable timescale.

It has been another busy and eventful year for my staff and I am most grateful to them all for their hard work and for the way they have supported me in laying the foundations for the new ombudsman service.

I am also grateful to my fellow UK public sector ombudsmen, who have been generous as ever in sharing their knowledge and experience and in offering practical support. Special thanks are due to Alice Brown, the Scottish Public Services Ombudsman, for enabling me to adopt and adapt the casework management system developed for Scotland, which has proven to be very suitable for our needs also.



Adam Peat
Ombudsman

2 Report of the Commissioner for Local Government in Wales

The Ombudsman's Jurisdiction

The jurisdiction of the Commissioner for Local Government in Wales is in two parts. First he has jurisdiction to investigate complaints from members of the public that they have suffered injustice as a result of maladministration by local authorities in Wales. Secondly he has jurisdiction to investigate allegations made against local authority members that they have breached their authority's code of conduct.

Complaints of Maladministration and Injustice

The term maladministration is not defined in the Local Government Act 1974 but it makes clear that (in the absence of maladministration) the Ombudsman is not to question the merits of a decision taken by an authority in exercising a discretion vested in it. In other words, the Ombudsman cannot enquire into and question a decision by an authority simply because a complainant disagrees with that authority's decision. He is, however, concerned with the way a decision has been reached. Examples of maladministration have included doing something the wrong way, doing something that should not have been done, delay in doing or failing to do something that should have been done, bias, basing a decision on improper or irrelevant considerations, giving wrong or misleading information, and breaches by councillors of the rules relating to conduct. Even if there is evidence of maladministration, however, the complainant must also be able to show that the maladministration has caused him or her an injustice which has not been remedied.

A number of matters are outside the Ombudsman's jurisdiction in any event, whether or not they involve maladministration which has caused injustice to the complainant. These include personnel issues (such as complaints by an authority's staff about the way the authority has behaved as an employer), commercial and contractual disputes (other than those related to the sale or purchase of land), matters which affect all or most inhabitants of a local authority's area and issues to do with conduct, the curriculum, the internal organisation of, the management of, or discipline within any local authority school or other educational establishment. Similarly, the Ombudsman cannot usually investigate complaints where the complainant has an alternative remedy for his or her grievance by way of an appeal to the National Assembly for

Wales, a government minister, or to a particular tribunal or through legal proceedings in a court of law. Complaints must be submitted in writing by or on behalf of the person aggrieved, and they should be submitted within twelve months of the complainant becoming aware of the matters giving rise to the complaint.

If a complaint appears to be within his jurisdiction, the Ombudsman must first give the authority against which it is made an opportunity to answer it. In giving an authority that opportunity the Ombudsman will usually ask the authority if it can settle the complaint. Where possible and appropriate he or his staff will try to help the authority and the complainant reach an amicable solution to the problem. Ultimately, however, it is for the Ombudsman to decide whether the complaint raises issues of wide public interest. In making that decision he will take into account what if anything further investigations could achieve, and whether they would result in a different and worthwhile outcome. If a complaint cannot be settled and further investigation is justified, the Ombudsman will usually issue a formal public report on his investigation (although the report will not contain anything which would enable the complainant to be identified).

The Ombudsman has the same powers as the High Court with regard to the production of documents and the examination of witnesses, but all enquiries by the Ombudsman must be conducted in private, and information obtained in the course of enquiries cannot be disclosed except for the purposes of any report on the complaint. If a complaint is upheld, and the Ombudsman finds that the complainant has suffered an injustice as a result of maladministration, he will usually recommend a remedy for the injustice. He may also make recommendations to the authority on steps it should take to avoid a repetition of the maladministration and of the injustice. The Ombudsman's findings are not legally binding on an authority, but are accepted in nearly all instances. If the Ombudsman is not satisfied with a response to one of his reports, he may issue a further report. If an authority fails to comply with recommendations in a further report, the Ombudsman can require the authority to pay for the publication of a statement in the press drawing attention to that failure. It is exceptionally rare for the publication of such a statement to become necessary, but beyond that step the Ombudsman has no further sanction at his disposal.

2

Allegations of Misconduct

All county, county borough and community councils, all fire and national park authorities and all joint authorities have to have a code of conduct (incorporating the provisions of a model code issued by the National Assembly for Wales) as to how their members should behave, and all members have to agree to abide by that code. Similarly, the police authorities also have to have a code of conduct, but in their case incorporating provisions issued by the Home Office. The Ombudsman has jurisdiction to investigate allegations that members of those authorities have failed to comply with their authority's code of conduct. Anyone can make an allegation, and the Ombudsman's jurisdiction to investigate the allegation is not restricted in the same way as his jurisdiction to investigate complaints of maladministration and injustice is restricted.

The Ombudsman has, nevertheless, a discretion whether to investigate an allegation or not, and he can discontinue an investigation at any stage. On completion of an investigation he may send a report on the outcome of his investigation to the monitoring officer of the authority concerned for consideration by its standards committee. Alternatively, he may send a report on the outcome of his investigation to the President of the Adjudication Panel for Wales so that the matter can be referred to a tribunal for adjudication. A standards committee can suspend a member for up to 6 months, and a tribunal can disqualify a member from office for up to five years.

The information that follows gives details of the complaints and allegation caseloads considered over the past year.

Complaints

County and County Borough Councils

It is pleasing to note that overall the number of complaints of maladministration continues to decrease. The number of complaints made against each authority will naturally fluctuate. This year, I published slightly more reports and made a formal finding of maladministration in four cases compared to three last year. However, there has also been an increase in cases where remedies for apparent maladministration have been achieved without having to undertake a full investigation, as councils were willing to recognise mistakes and provide a satisfactory remedy without the need for me to publish a public report.

The information on the following page gives further details on the complaints I have received in respect of the 22 county and county borough councils in Wales.

Complaints

Authority Complained about	Enquiries		Total Complaints assessed/ investigated	
	2004/05	2003/04	2004/05	2003/04
Blaenau Gwent CBC	9	10	11	11
Bridgend CBC	20	15	29	21
Caerphilly CBC	19	17	25	29
Cardiff CC	25	38	34	43
Carmarthenshire CC	35	36	45	45
Conwy CBC	10	20	13	29
Cyngor Sir Ceredigion	17	16	25	21
Denbighshire CC	19	25	23	28
Flintshire CC	15	18	19	24
Gwynedd CC	15	26	20	34
Isle of Anglesey CC	11	13	14	13
Merthyr Tydfil CBC	13	10	16	14
Monmouthshire CC	20	15	24	20
Neath Port Talbot CBC	11	20	14	28
Newport CC	17	17	20	26
Pembrokeshire CC	15	25	21	36
Powys CC	22	23	28	30
Rhondda Cynon Taff CBC	19	15	29	28
Swansea City & County	14	17	18	29
Torfaen CBC	28	23	32	18
Vale of Glamorgan CBC	22	14	27	28
Wrexham CBC	3	13	5	19
TOTAL	**379**	**426**	**492**	**574**

[Note: the abbreviations used in the last two columns of the above table represent the following:
(M) – Maladministration
(NM) – No maladministration
(D) – Discontinued before report

Complaint assessed but not pursued		Remedy achieved without full investigation		Full investigation with public report issued or discontinued	
2004/05	2003/04	2004/05	2003/04	2004/05	2003/04
10	11	1	-	-	-
19	13	9	8	1 (M)	-
20	24	5	5	-	-
26	36	7	7	1 (M)	-
38	37	6	6	1 (NM)	1(M); 1(D)
9	26	3	3	1 (M)	-
25	18	-	3	-	-
18	25	5	3	-	-
15	22	4	1	-	1(M)
17	29	3	3	-	1(M); 1(D)
12	17	2	2	-	-
14	13	2	1	-	-
20	16	4	4	-	-
12	23	2	5	-	-
16	24	3	2	1 (D)	-
16	30	4	6	1 (M)	-
22	28	3	-	3 (D)	1(NM); 1(D)
25	23	4	5	-	-
14	25	4	4	-	-
22	26	8	2	2 (D)	1(D)
24	15	3	2	-	-
5	16	-	3	-	-
399	**497**	**82**	**75**	**11**	**8**

2

Authorities Abolished on 31 March 1996

Although local government re-organisation occurred in 1996, a very few complaints in respect of the authorities that existed prior to this still arise.
Details of complaints examined this and last year are set out below.

Authority Complained about	Enquiries		Total Complaints assessed/ investigated	
	2004/05	2003/04	2004/05	2003/04
Former Powys County Council	-	-	1	-
Mid Glamorgan CC	-	-	-	1
TOTAL	-	-	1	1

National Park Authorities

Authority Complained about	Enquiries		Total Complaints assessed/ investigated	
	2004/05	2003/04	2004/05	2003/04
Brecon Beacons	3	6	4	8
Snowdonia	1	1	3	1
Pembrokeshire	-	5	-	8
TOTAL	4	11	7	17

Complaint assessed but not pursued		Remedy achieved without full investigation		Full investigation with public report issued or discontinued	
2004/05	2003/04	2004/05	2003/04	2004/05	2003/04
1	-	-	-	-	-
-	1	-	-	-	-
1	**1**	**-**	**-**	**-**	**-**

Complaint assessed but not pursued		Remedy achieved without full investigation		Full investigation with public report issued or discontinued	
2004/05	2003/04	2004/05	2003/04	2004/05	2003/04
3	7	1	1	-	-
3	1	-	-	-	-
-	5	-	3	-	-
6	**13**	**1**	**4**	**-**	**-**

Education Bodies within jurisdiction

Authority Complained about	Enquiries		Total Complaints assessed/ investigated	
	2004/05	2003/04	2004/05	2003/04
Appeals Panel – Cardiff High School	1	-	1	-
Appeals Panel - Hawarden High School	2	-	2	-
Corpus Christi Governing Body	-	-	1	-
Independent Admissions Appeal Panel – Corpus Christi R/C High School	-	-	1	-
Appeal Panel – Rhydypenau Primary School	-	1	-	1
Appeals Panel – Castell Alun Hugh School	-	1	-	1
Appeal Panel – Peniel School	-	2	-	2
Appeal Panel – Alun School, Mold	-	1	-	1
Governing Body – Bishop of Llandaff Church School	-	-	-	1
TOTAL	3	5	5	6

Overall Total

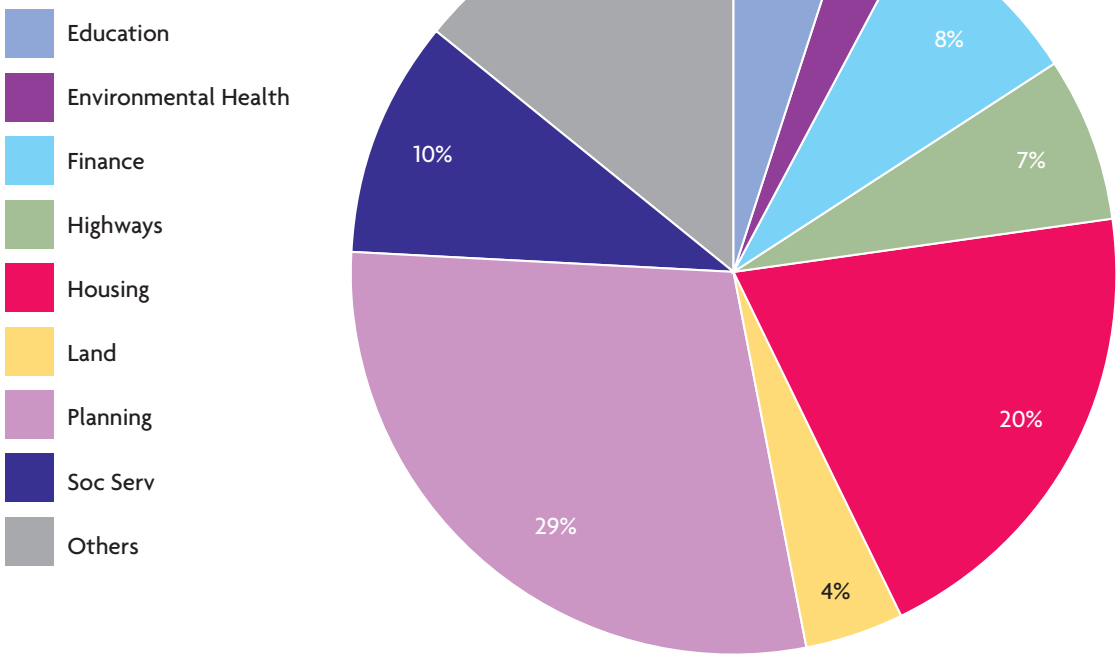
Enquiries		Total Complaints assessed/investigated		Complaint assessed but not pursued	
2004/05	2003/04	2004/05	2003/04	2004/05	2003/04
386	443	506	605	412	517

Complaint assessed but not pursued		Remedy achieved without full investigation		Full investigation with public report issued or discontinued	
2004/05	2003/04	2004/05	2003/04	2004/05	2003/04
1	-	-	-	-	-
2	-	-	-	-	-
1	-	-	-	-	-
1	-	-	-	-	-
-	1	-	-	-	-
-	-	-	1	-	-
-	2	-	-	-	-
-	1	-	-	-	-
-	1	-	-	-	-
5	**5**	**-**	**1**	**-**	**-**

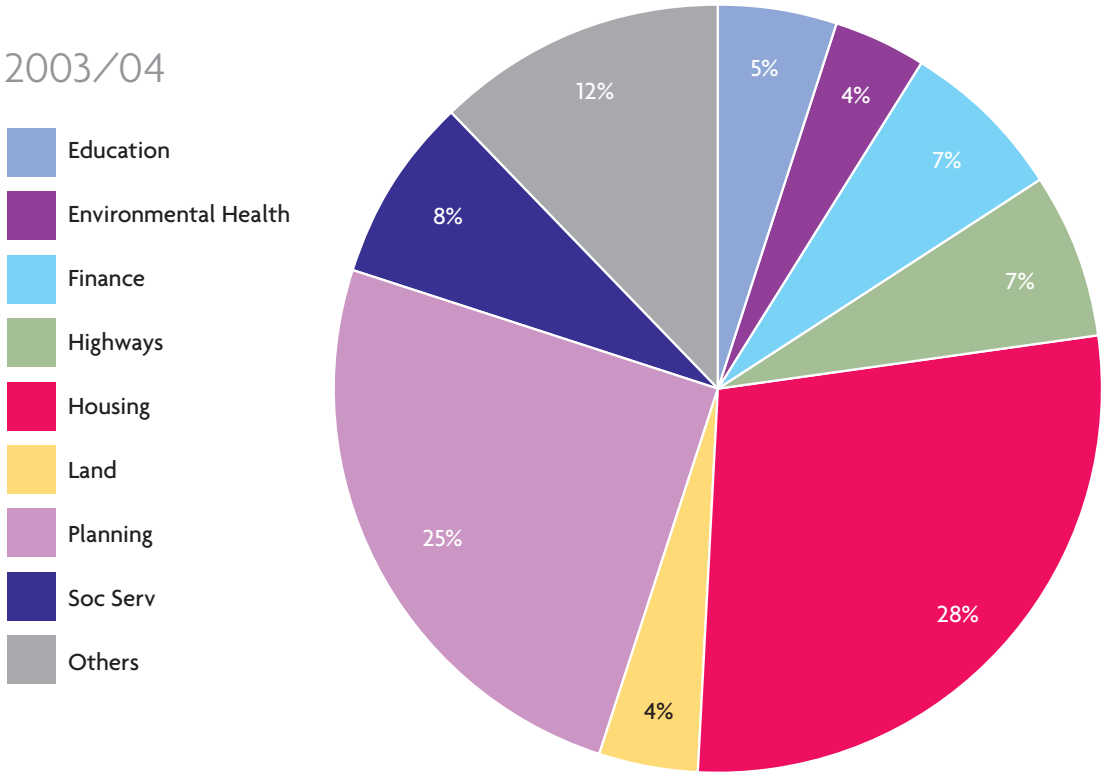
Remedy achieved without full investigation		Full investigation with public report issued or discontinued	
2004/05	2003/04	2004/05	2003/04
83	80	11	8

Incidence of Complaints by Service Area

2004/05



2003/04


Education
Environmental Health
Finance
Highways
Housing
Land
Planning
Soc Serv
Others
5%
4%
7%
7%
28%
4%
25%
8%
12%

Reasons for terminating enquiries

Section of 1974 Act	Reason	Number of complaints 2004/05	2003/04
26(1)	Not an authority subject to investigation or person not entitled to complain as a member of the public	24	38
26(1)	Injustice/maladministration not evident	269	335
26(4)	Complaints not made within 12 months	24	16
26(5)	Not brought to attention of authority	7	11
26(6)(a)	Alternative remedy by: Appeal to a tribunal	6	16
26(6)(b)	Appeal to National Assembly or a Minister of the Crown	17	12
26(6)(c)	Proceedings in court of law	44	63
26(7)	Affecting all or most of inhabitants of area	10	6
26(8)	Action connected with Schedule 5: Para (1) Commencement of civil or criminal proceedings Para (2) Investigation or prevention of crime Para (3) Contractual or commercial matters Para (4) Personnel matters Para (5) Excluded education matters	 1 0 6 7 1	 5 0 2 8 4
26(10)	Discretionary decision not to investigate further	14	30
26(10)	Discretionary decision not to investigate further – settled	29	34
26(10)	Settled to complainant's satisfaction	33	36
26(10)	Withdrawn by complainant	21	10
26(12)	Matters arising before 1st April 1974	0	1
27	Body not entitled to complain	2	2

Summaries of Complaints Cases

Planning Decision – Carmarthen County Council

The Ombudsman received a complaint that the Council granted the complainant's neighbour planning permission to build a detached bungalow in the rear garden of the neighbour's terraced home. The complainant said that decision to grant planning permission for the development was contrary to the Council's development and local plan in force at the time the decision was made. The complainant alleged that in arriving at its decision the Council was unduly influenced by his neighbour's personal circumstances.

The planning application complained of was the second such application considered by the Council. The first application was subject of an appraisal by a planning officer and he recommended that the Council's Planning Committee refuse that application. The Committee decided to refuse the application in accordance with its officer's advice. A second planning application was then made by the neighbour. This application was almost identical to the first application except that the proposed dwelling was described as "a detached bungalow to be occupied by a disabled person". The planning officer again recommended refusal as contrary to the planning policy of the Council but after a site visit the Committee granted the application subject to conditions.

The Ombudsman, having interviewed the members of the Planning Committee, concluded that there was no evidence to indicate that they had failed to consider appropriately the relevant matters, including the advice of the planning officer. The decision which the Committee took was reached in a proper manner and was not manifestly unreasonable; accordingly it was not for the Ombudsman to question its merits. The complaint was not upheld.

Social Services – Conwy County Borough Council

The Ombudsman received a complaint that the Council wrongly charged for after care services provided under Section 117 of the Mental Health Act 1983. The complainant was particularly aggrieved by the decision of the Council (in conjunction with the local health authority) to stop providing after care services for his late mother without consulting him. He regarded this decision as unreasonable. The Ombudsman investigated this complaint and found that there had been maladministration by the Council as it was not entitled to charge for Section 117 after care services and the decision to withdraw those services was unlawful. The Ombudsman found also that the Council's procedures for planning after care services did not comply with those set out in a code of practice issued under the provisions of the Mental Health Act 1983.

The Council responded positively to the Ombudsman's findings and made full and proper restitution to the complainant to the sum of some £117,000. It agreed also to identify other individuals and their families who may have been wrongly charged for after care services and put in place arrangements for reimbursing them or their estates as soon as possible. At the Ombudsman's suggestion, it agreed also to fully implement the recommendations contained in a Special Report issued by the Local Government Ombudsman in England which contained advice and guidance on the funding of aftercare under Section 117 of the act.

Social Services – Cardiff County Council

The complainant contacted the Council, via her MP, regarding adaptations to her property. She had problems with mobility and in particular difficulties in climbing the stairs.

The Council, although under a duty to assess her needs delayed for six months before carrying out an assessment. When the assessment was carried out, after further prompting from the complainant, it was thought that the complainant's 'contribution' would exceed the cost of the work. The appropriate advice, to complete the necessary application even though this would have resulted in a 'nil approval', was not given. Council officers say that this was not their normal practice. They failed to

follow government advice which would have had implications for other disabled people in the Council's area when making successive applications for grant aid for adaptations. For the complainant this resulted in subsequent delays when she sought financial help for the funding of a stairlift from a national benevolent fund.

The complainant's stairlift was eventually installed but 18 months later than it could have been because the necessary paperwork was not in place. The Ombudsman found that there had been maladministration by the Council. The Council accepted his recommendations to pay the complainant compensation of £1000 and to review its procedures, including staff training.

Social Services – Bridgend County Borough Council

The complainant, who was an amputee, asked the Council in October 2002 to improve the access to his flat to enable him to use his invalid scooter. A ramp was already in place to enable easy access to and from his front door but he was unable to turn and exit safely from his front garden gate onto the footpath. The complainant was put onto the 'B2' priority waiting list. The Council had set a target that assessment of people on this waiting list should be completed within four months of referral to the team.

An assessment of the complainant's needs was not carried out until 14 May 2003; several months later. The occupational therapist recommended adaptations to improve the access to provide a wheelchair ramp and turning platform to enable the complainant to turn onto the public footpath. Technical inspection of the property was carried out on 23 July 2003. The complainant complained to the Ombudsman in early September 2003. In the meantime he had sold his invalid scooter and lost money on the sale. The Ombudsman found that there had been delay on the part of the Council and that it had not been sufficiently responsive in its approach to cope with the increased number of referrals made to it. The Ombudsman found that there had been maladministration on the part of the Council. The Council accepted his recommendation to pay the complainant compensation of £1,000.

Social Services – Pembrokeshire County Council

The complainant is the mother of four children. She says that the Council unreasonably and insensitively conducted an investigation of the way she treated her children; that the children were placed on the register of children at risk by a subsequent child protection conference on the basis of incorrect and misleading information and that her complaints about the initial investigation and the child protection conference were mishandled by the Council with the result that the children were wrongly retained on the register for longer than they should have been.

The Ombudsman found that social workers failed to follow the appropriate procedures in a number of ways and although he did not criticise the decision to make inquiries he was not satisfied with the way in which those inquiries were conducted. He was critical of the failure of the social workers involved to make adequate preliminary inquiries before speaking to the complainant and her children. The Ombudsman was also critical of the insensitivity shown by social workers towards the family. The result was that the complainant and her children suffered distress, embarrassment and humiliation.

The investigation uncovered no evidence that the family was receiving the support from social work staff that it was meant to be getting. The Council failed to comply with the guidance on good practice when arranging the initial Child Protection Conference and the investigation identified procedural and administrative faults on the part of the Council officers involved which significantly affected the outcome. The Ombudsman concluded that on the balance of probabilities had these faults not occurred the conference would not have take the decision to place the children's names on the at risk register. The injustice to the complainant was exacerbated by the fact that the Council mishandled her complaint at stage 1 of the Social Services statutory complaints procedure. This meant that she had to pursue the complaint through the remainder of the process.

The Council also failed to follow the prescribed procedures in place when it arranged the first review child protection conference. These failures were compounded by the failure to give the complainant clear information on how to pursue her concerns

about the way in which the initial review conference had been conducted. As a result she was prevented from appealing the decision because she was out-of-time. There was also a clear breach of procedures leading up to the second review conference with the result that the decisions reached at successive conferences to retain the children's names on the register were "seriously procedurally flawed". The Ombudsman commented that the council's track record in dealing with the complainant and her children had been "lamentable", and that despite the obvious shortcomings in its handling of the various complaints, appeals and representations, the Council's approach to making redress in respect of the serious complaints which had been up-held via the statutory complaints procedure had been "grudging and ineffectual".

To remedy the injustice the Ombudsman recommended that the Council should apologise fully to the complainant and acknowledge clearly that the children should not have been placed on the at risk register. In addition he recommended that the Council should pay the complainant £5,000 in recognition of the severe distress and the reputational damage which its maladministration had caused and of her time and trouble in pursuing her complaints. He recommended too that the Council should say sorry to the children through the complainant. He further recommended that the Council should by no later than the end of June 2005 carry out a formal review with external assistance of the lessons to be learnt from the events set out in the report. The Council should then implement "promptly and vigorously" any procedural improvements required to its procedures or to staff training.

The Council accepted the Ombudsman's recommendations in full. It has apologised to the complainant and has paid her the sum of £5,000. In addition to this, the Council commissioned an experienced external consultant to undertake the review recommended by the Ombudsman. That review has been completed and the Council has committed itself to delivering the Action Plan arising from the recommendations of that review. Beyond this, the Council has also commissioned a multi-agency management review, which will incorporate the external consultant's report alongside reports from the health, education and police services.

Housing Benefit – Vale of Glamorgan

The complainant was aggrieved by the time taken by the Council to determine his claims for housing benefit and with the way in which it sought to recover an overpayment of benefit paid to him. Following the Ombudsman's intervention, the Council acknowledged that there had been errors and administrative shortcomings in dealing with the claims. It offered to apologise and to pay the complainant £75 in recognition of the distress he had experienced as a result and for the time and trouble of complaining to the Ombudsman. The Council also agreed to conduct a review of its arrangements for dealing with housing benefit claims with a view to reducing delay. In view of this the Ombudsman decided not to pursue his investigation to the issue of a formal public report.

However, when this report went to press, the Council had yet to satisfy the Ombudsman that it has completed the review and that it is taking effective action to determine housing benefit claims in a timely manner and in accordance with the regulations.

Allegations

There is a slight fall in the number of new allegations received this year, but the fall is so small so that it is not possible to reach any firm conclusions.

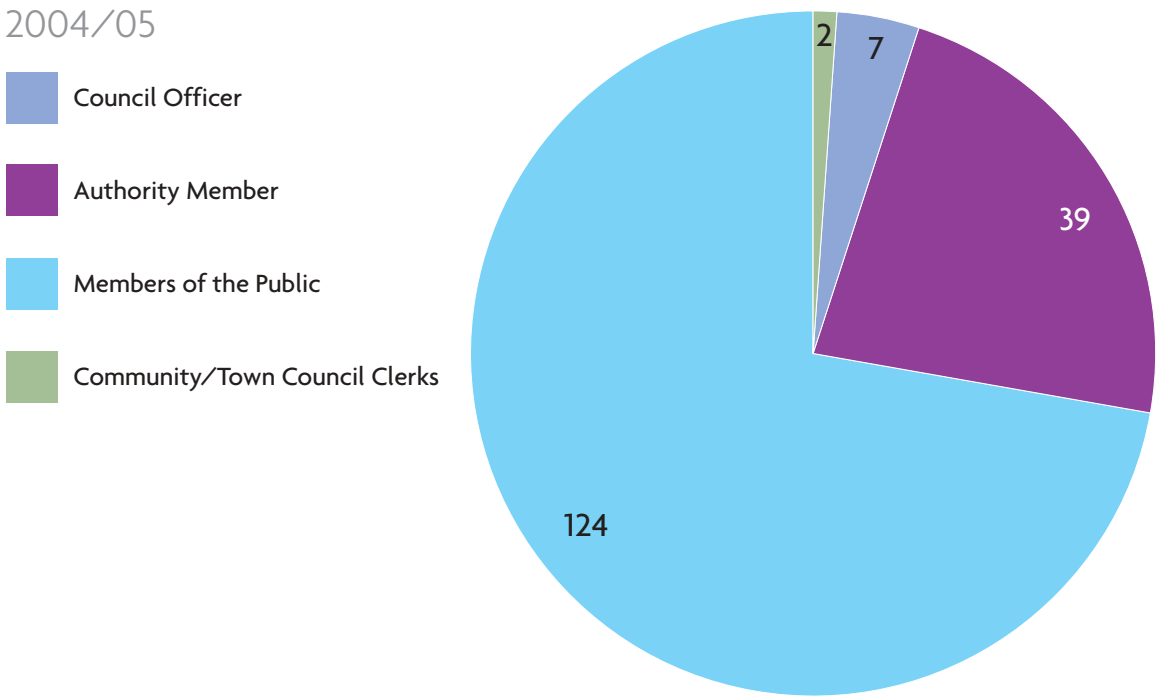
The allegations against community/town councillors continue to be the largest group of allegations received, although it does have to be borne in mind that there are 736 community councils and a correspondingly large number of community councillors. Many of these complaints are trivial in their nature, while some appear to indicate that community councillors are uncertain about their council's rules and procedures for meetings. There may be a need for additional training for community councillors in this area.

I have received a considerable number of allegations by members of community councils against another member of that council. In the case of one particular community council, the level of "tit-for-tat" allegations made by councillors against one another during the year causes me some concern that personal animosities may be adversely affecting the ability of the council to serve the community effectively.

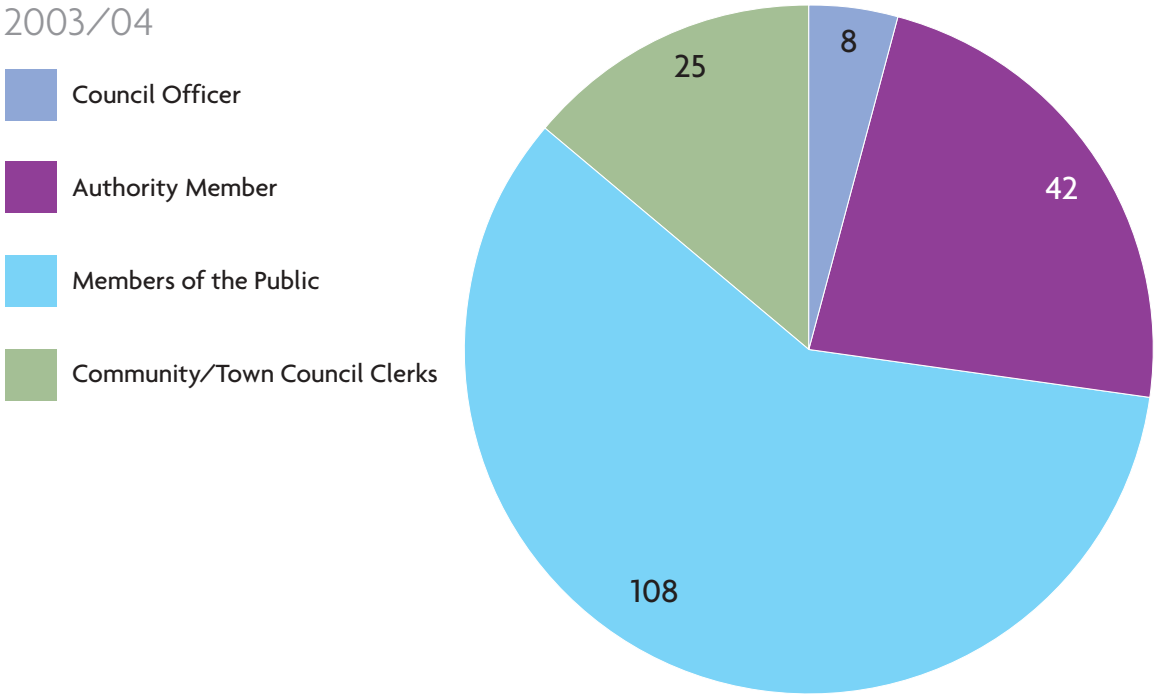
On a more positive note, none of my investigations during the year under review found evidence of misconduct which was sufficiently severe to warrant reference to the Adjudication Panel for Wales, and there were very few cases which I thought it appropriate to refer to the relevant council's standards committee. I believe that the framework for ethical standards is working well and that standards of conduct in local government in Wales are high.

Source of Allegation: Number and Category of Persons Making the Complaint

2004/05

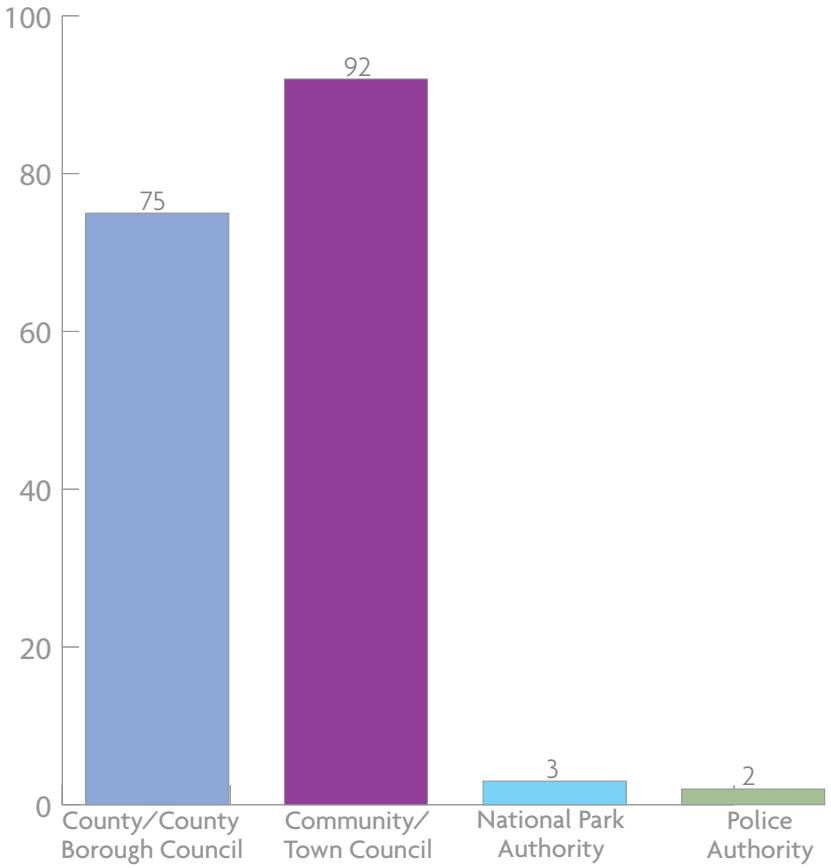


2003/04


Council Officer
Authority Member
Members of the Public
Community/Town Council Clerks
8
42
108
25

Type of authority to which accused member belongs

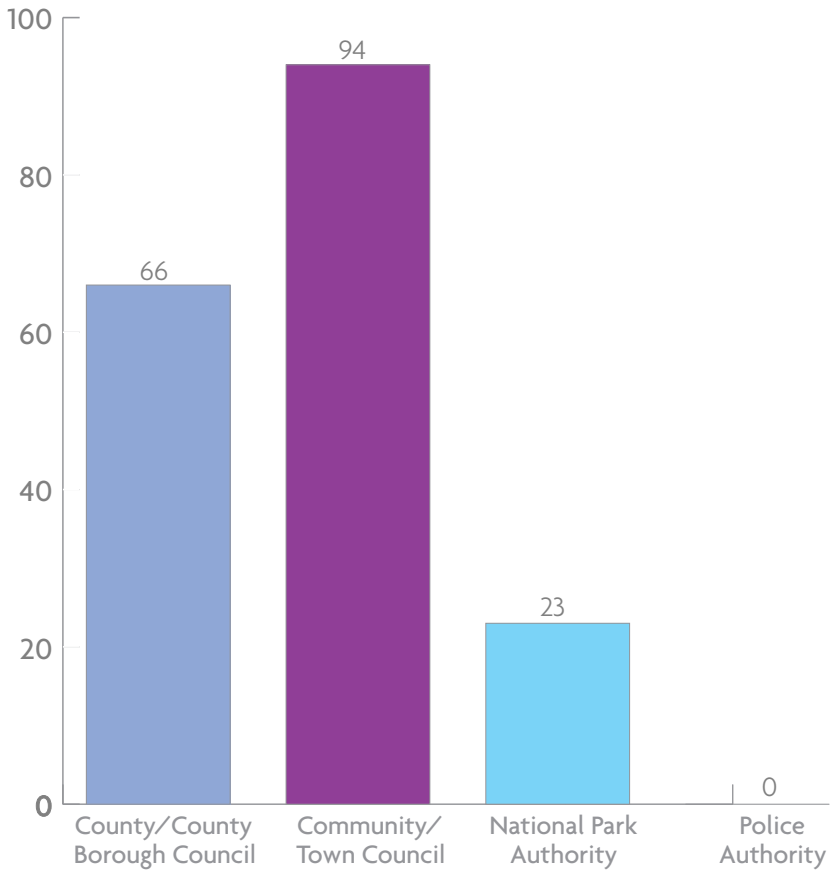
2004/05



Outcome of Investigations 2004/05

Decision not to investigate
Investigation discontinued
Investigation discontinued and referred to Monitoring Officer
Full investigation – no breach
Full investigation – breach but no action warranted
Full investigation – breach and referred to Authority's Standards Committee
Full investigation – breach and referred to the Adjudication Panel for Wales

2003/04



	Type of Authority to which Accused Member Belonged		
	County/County Borough Council	Community/Town Council	National Park Authority etc
	36	28	4
	13	13	1
	11	46	-
	12	4	-
	1	-	-
	2	1	-
	-	-	-

Paragraphs of Code of Conduct alleged to have been breached

Paragraph	Description	Number	
		2004/05	2003/04
4(a)	Failure to treat with equality & respect	35	35
4(b)	Compromising officers' impartiality	-	2
5(a)	Breach of Confidence	2	17
5(b)	Denial of access to information	5	1
6(1)(a)	Committing a criminal offence	4	3
6(1)(b)	Disreputable Conduct	63	64
6(1)(e)	Vexatious or malicious allegations	5	3
7(a)	Seeking gain for family/friends	4	6
7(c)	Use resources for personal gain	3	2
8(a)	Not acting objectively	4	5
8(b)	Failure to heed officer advice	-	1
16&17	Failure to disclose interest	35	32
	Unspecified	12	12

Allegation Case Summaries

Failing to show respect and consideration for others - City & County of Swansea

The Ombudsman received an allegation that a member failed to show respect and consideration for others because the member spoke in the Welsh language at a Council meeting. When he was asked to speak in English by a member of the public it was alleged that the member responded inappropriately.

The Ombudsman investigated the allegation and found that the Council's procedures gave equal prominence to both the English and Welsh language. The member was therefore entitled to address the meeting through the medium of Welsh and it was the Council's responsibility to ensure that translation services were available.

In respect of the response made by the member to the request to speak in English the Ombudsman concluded that even if the response amounted to a breach of the code it was insufficiently serious to warrant further investigation.

Failing to show respect and consideration for others - Llandysul Community Council

The Ombudsman received an allegation that the Chairman of a Community Council addressed a member of the public in a demeaning manner when he asked the member of the public to stop reading a newspaper in a council meeting as the Council was about to consider a letter from that member of the public.

The Ombudsman declined to investigate the allegation as he considered that the conduct complained of did not amount to a breach of the code.

Failure to Declare an Interest - Brecon Beacons National Park

The Ombudsman received an allegation from the Monitoring Officer of a national park that a member failed to disclose an interest in a planning application. The Monitoring Officer had advised members of the Development and Control Committee of the Authority that as a planning application they were considering was made by a long-standing member of the Authority, other long-standing members should consider whether they should disclose an interest on the basis of a close personal association with the applicant. Following that advice the committee adjourned its meeting and several members subsequently obtained dispensations from the Authority's Standards Committee. The member against whom the allegation was made concluded that he did not have a close personal association with the member making the planning application as the only association he had with that member was as a member of the authority.

After investigating the allegation the Ombudsman determined that there was no breach of the code of conduct.

Failure to Declare an Interest - Dunvant Community Council

The Ombudsman received a number of allegations from members of a Community Council about fellow Council members. The common theme of the allegations was that the members were alleged to have breached the Council's code of conduct for members in that they failed to declare interests in a matter which came before the Council for discussion. The matter concerned was the up-keep of an access way.

The one member against whom an allegation was made lived next door to the access way and was a tenant of the housing association responsible for maintaining it. In the case of the other member, her daughter lived very near the access way and was also a tenant of the housing association. Albeit that the second member did not accept that she had a personal interest she applied to the Standards Committee of the City and County of Swansea for a dispensation to speak and vote on the matter, having been advised by One Voice Wales that she did have an interest to declare. Her application was refused. Both members participated in subsequent discussions of the matter at Council meetings.

In the case of the first councillor the Ombudsman found that the fact that he lived in such close proximity to the access way and that he was a tenant of the housing association meant that his assertion that he did not have an interest to declare was unreasonable. The Ombudsman was also satisfied that a member of the public would have concluded that it would have affected his ability to act purely on the merits of the case and in the public interest. That being so he should have withdrawn from the meeting.

The Ombudsman found in relation to the second member that her application to the Standards Committee for a dispensation was a tacit admission that she had an interest to declare. He was satisfied too that the nature of her interest was such that a member of the public might reasonably conclude that it would significantly affect her ability to act on the merits of the case and in the public interest. That being so she should have withdrawn from the meeting.

The Ombudsman found that the second member had also breached paragraph 20 of the code of conduct which states "members must exercise personal responsibility in deciding whether they have a personal interest such that they should disclose it. They may seek advice from the authority's monitoring officer and must have regard to any advice from the relevant standards committee in doing so." This was because of her "flagrant disregard" of the decision by the Standards Committee to refuse her a dispensation.

Both cases were referred by the Ombudsman to the Monitoring Officer of the City and County of Swansea for consideration by that Council's Standards Committee. In the case of the first member the Standards Committee found that he had breached the Code and decided that he should be censured. The Committee recommended that he should familiarise himself with the code of conduct and its implications.

The Committee found that the second member had breached the code not only by failing to declare an interest but also by her disregard of the decision by the Committee not to grant her a dispensation to speak and vote on the matter. For the first breach she was suspended for a period of three months; for the second she was suspended for a period of four months. The Committee determined that both periods of suspension should run concurrently. The second member has appealed to the Adjudication Panel for Wales. The appeal has yet to be heard.

3 Report of the Welsh Administration Ombudsman

I was appointed as Welsh Administration Ombudsman in November 2004 in succession to Ann Abraham, who remains as Parliamentary Ombudsman as well as Health Service Commissioner for England. I want to thank Ann most warmly, not only for her service to Wales as my predecessor, but also for the practical help which she has given me since I took up office.

The Welsh Administration Ombudsman investigates complaints from members of the public that they have suffered injustice because of maladministration by the National Assembly for Wales or certain public Assembly Public Sponsored Bodies. The nature of the Ombudsman's jurisdiction, and the constraints upon it, are closely similar to that of the Commissioner for Local Administration (described at page 7). Ann Abraham has already reported upon elements of casework undertaken for the six months April to September 2004 in the Annual Report that she published for 2003/04.

However, in order to apply a consistent approach within this overall document, the figures below report on workload across the whole period April 2004 to March 2005 (although the summaries of case studies reported on later in this report relate to the period between September 2004 and March 2005.)

Complaints

The number of complaints received by my office during 2004/05 was 42, compared to 64 in 2003/04. It is pleasing to see that that the number of complaints that I receive as Welsh Administration Ombudsman has continued to fall, from what was already a fairly low base. Similar to previous patterns, the majority of the complaints that I received were in relation to the National Assembly for Wales. However, given the wide scope of the Assembly's responsibilities this is not unexpected. Of the 17 complaints received in 2004/05 against the National Assembly for Wales, four were in relation to health matters, four in respect of agriculture, and three concerned highways issues.

Bodies complained about	Cases carried forward		New Complaints	
	04/05	03/04	04/05	03/04
Arts Council of Wales	1	1		
Countryside Council for Wales	1		1	2
Care Standards Inspectorate for Wales			1	
Environment Agency				4
Environment Agency for Wales	1	1	1	2
Forestry Commission			1	
Higher Education Funding Council for Wales	1	1		
Local Authorities		15	4	
Office of HM Chief Inspector of Schools for Wales		1		1
National Assembly for Wales	10	8	17	26
Planning Inspectorate	2	1	9	5
Sports Council for Wales			1	
Wales Tourist Board	1			1
Welsh Development Agency		1	1	2
Welsh Historic Monuments		1		
Other			6	5
TOTAL	**17**	**14**	**42**	**64**

Concluded without Investigation		Investigations						Total	
		Justified		Partly Justified		Not Justified			
04/05	03/04	04/05	03/04	04/05	03/04	04/05	03/04	04/05	03/04
				1				1	
2									
1									
	4								
	1		1	1				1	1
1									
1									
4	15								
	2								
23	20	1	2			1		2	2
7	6								
1									
1	1								
1	2						1		1
4	1								
4	5								
50	**57**	**1**	**3**	**2**		**1**	**1**	**4**	**4**

Summaries of Cases

The Environment Agency (The EA): Mishandling of an application for a discharge consent

Mr F's neighbour, Mrs X, applied to the EA to discharge biologically treated effluent into a below ground surface drain, which, in turn, discharged into a ditch running through Mr F's land. EA decided that the application did not require advertising. Having learnt of the application from his local authority, Mr F then telephoned the EA to say that he was not prepared to allow the discharge to his land. He later expressed concern about the application and that he had not been consulted about it. He also queried whether EA had the power to grant a consent for disposal of effluent to land not owned by the applicant and to which they only had a legal right to discharge surface water, and if so, how he could appeal against their decision. Mr F made further representations against the application; he also believed he had secured the EA's agreement to undertake a site visit, to which he would be invited. The site visit took place, but Mr F was unaware of that. EA replied to Mr F's representations and informed him that the application had been granted. EA told him that he could appeal against the decision to the National Assembly for Wales (but such a right applied only to applicants).

Mr F then complained to the EA that they had failed to reply to his reasonable questions about the application, that he had not been invited to the site meeting, and had been wrongly told that he could appeal against the consent. In subsequent correspondence Mr F raised many concerns about the EA's handling of the application. The EA's replies failed to satisfy Mr F. Following a subject access request made under the Data Protection Act, the EA provided Mr F with relevant information, which led him to raise further issues. These included an internal email sent by an EA officer that had referred to concerns that if EA staff did meet Mr F on site it would lead to a 'confrontation'. Mr F also said that he had been mis-advised of the Assembly's powers to call-in the application.

Findings

The Ombudsman considered that the EA's decision not to advertise Mrs X 's application was within their discretion, but welcomed the EA's conclusion that they would consider whether advertising should be expanded to cover cases where there is known interest in the application, or whether such cases could be addressed through the targeted consultation of individuals. The Ombudsman found no evidence to suggest that the EA had not taken Mr F's concerns about the application seriously, however the level of customer service had often been very unsatisfactory. They had effectively deprived Mr F of the opportunity of asking the Assembly to call-in the application. She also criticised the EA for failing to honour their undertaking to invite Mr F to the site visit, as well as for a number of administrative errors. She found shortcomings in the EA's handling of Mr F's complaints.

Remedy

The EA's Chief Executive accepted that their performance had been unsatisfactory and apologised for that. She said that lessons had been learned and that procedural changes would be made. The EA would offer Mr F an ex gratia payment of £500 in recognition of the severe inconvenience he had suffered, and would also reimburse him any reasonable expenses that he had incurred in pursuing his complaint about their handling of the discharge.

The National Assembly for Wales (the Assembly): compulsory purchase of land

Mr X complained about the way in which the then Welsh Office (WO) and, subsequently, the Assembly handled the compulsory purchase of land he owned. The case was particularly complex and stretched back to 1981 when the WO developed plans to construct a link road from the A48 west of Cardiff to a new junction on the M4 motorway to the north, mainly following the route of a disused railway line. Mr X was the owner of a parcel of land in the vicinity of the proposed route comprising three fields which, along with land owned by three of Mr X's neighbours (Mr Y, Mr Z and Mr W), carried a right of access across the disused line by way of a bridge. The construction of the planned road required the removal of the bridge and WO proposed to make alternative arrangements for access to Mr X's and his neighbour's

land, across land owned by Mr X and his neighbour, Mr Y. On 7 April 1982, the Secretary of State confirmed the compulsory purchase order (CPO) for the purchase of land and rights for the construction of the road.

The CPO required the acquisition of Mr X's land where it was to be crossed by the link road, and where it was to be crossed by the new access road. In May 1982 the Valuation Office wrote to Mr X to open negotiations for the purchase of the land on behalf of the Secretary of State. In 1983 Mr X appointed an agent to act on his behalf in the negotiations. Meanwhile, Mr X had entered into negotiations with another of his neighbours, Mr Z, to purchase land which had an alternative right of way over land owned by Mr Y. Negotiations between the parties about the various rights of way to be afforded to the landowners and other matters, including compensation, became seriously protracted over a period of 15 years and it proved impossible to reach an agreement. Mr X had been particularly keen to avoid the necessity for WO to fulfil the CPO but had been unable to agree with his neighbours the terms under which he would grant them rights of way over the new access road which WO had constructed on his land. Eventually, in February 1997, the Valuation Office wrote to Mr X's agent to say that there appeared to be two options available to resolve the dispute: either for Mr X to retain ownership of the land and to grant rights of way, either conditionally or unconditionally, by agreement, or for the Secretary of State to proceed with the CPO and to assign rights of way to the parties.

The Valuation Office said that because of the inability to reach an agreement, WO proposed resorting to the second option and, unless Mr X stated within 10 days that he was prepared to grant unconditional rights of way to his neighbours, they would refer the matter to the Lands Tribunal (the Tribunal).

In March 1997, WO instructed their agents (the Treasury Solicitor's Department) to prepare a reference to the Tribunal. Mr X and his agent exchanged further correspondence with WO and the Valuation Office in attempt to resolve the matter short of a Tribunal hearing. A further exchange of correspondence failed to resolve the matter, and so on 9 January 2001, a Tribunal hearing took place. The Tribunal issued their decision on 15 January 2001, and determined a number of matters relating to the compulsory purchase. A dispute then arose over the awarding of costs, and the

Tribunal eventually decided that, in view of the conduct of the claim, to award the Assembly (who had by then succeeded WO) costs of some £17,000.

Mr X then complained to the Ombudsman about the manner in which WO and the Assembly had handled the case. He complained particularly that WO had instructed him to reach agreement with his neighbours on their rights of way over his land when, as his neighbours had introduced changes to the rights of access, the onus should have been on them to seek his agreement. Furthermore, he complained that WO's actions during the negotiations had made it impossible to reach an agreement without reference to the Tribunal, yet he had unreasonably incurred significant costs. He also complained that WO had been unable to explain how the new access road had been constructed in tarmac rather than the original agreed specification of a 'stone track', and that the tarmac finish would result in significantly higher maintenance costs to Mr X. He complained, too, that the Assembly had permitted fencing to be placed across a gateway immediately adjacent to a cattle grid straddling the new access road, and had thus deprived him of access for driven stock. Finally, he complained that the Assembly unreasonably proceeded to execute the CPO when he had been prepared to reach agreement by negotiation, and that the only reason the Assembly did so was to deprive him of the rights he had purchased with his property and to impose arbitrary and unspecified conditions for the benefit of others.

Findings

The Ombudsman found that there were some aspects of the case that WO could have handled better and that there were shortcomings in the standard of their correspondence. In respect of the surface of the access road, the Ombudsman found that it was not clear when the works for the access road were completed, but Mr X had first raised concerns about the use of tarmac and its future maintenance costs in October 1986. Investigations revealed that the tarmac appeared to have been laid as a result of an agreement between Mr Y and WO's contractors.

WO and the Valuation Office took until February 1997 to formally address Mr X's concerns about the issue of maintenance of the road and to agree that an element of

compensation in respect of Mr X's future maintenance obligations was warranted. In respect of the obstruction of Mr X's alleged rights to drive stock over the access road, the Ombudsman found that the Assembly's position that the fencing had replicated the pre-existing situation was reasonable, as Mr X had been unable to adduce any evidence of the rights he claimed. As things stood, Mr X had the ability to carry animals over the track by vehicle, but no more than that. However, the Ombudsman considered that the main failure in the case was Mr X's own inability to reach agreement with his neighbours regarding rights of way over the access road. While he criticised WO and the Assembly for failing to take a robust line with Mr X's failure to reach agreement with his neighbours at an earlier stage, Mr X had been, in many ways, the architect of his own misfortune. As such Mr X's complaint was upheld only in part.

Remedy

The Permanent Secretary of the Assembly agreed to apologise to Mr X for the shortcomings identified and to offer him an ex-gratia payment of £1,000 in recognition of any inconvenience Mr X had suffered.

The Arts Council for Wales (the Council): Mishandling of a lottery grant application and subsequent appeal

Mrs D was chair of a charitable Trust set up to advance public education in, and knowledge of, the history of the northern area of West Wales, through, in particular, the organisation of community events to celebrate a significant local event of the late 1700's. The Trust's long term aim was to provide a permanent home for a unique piece of art which chronologically depicted the event. The Trust prepared a feasibility study for a project which included building a facility to house the artwork, but also to provide galleries and workplaces for local craftspeople and a venue for a year round programme of art, craft and cultural events. In January 2002, Mrs D, on behalf of the Trust, applied to the Council for a grant of £800,000 towards construction costs.

The application was considered initially by the Council's capital committee (the committee) and then by the full Council, who decided that they required further information before reaching a decision. In July, the Council asked the Trust to provide

a formal risk analysis, up to date cost estimates and an update on the progress with other partnership funding applications. The Council also appointed two external assessors to consider the merits of the application.

Mrs D sought advice from officers of the Council about the extent of the information required. The Trust were also anxious that their application be considered at the next meetings of the committee and the Council, which were on 27 September and 11 October respectively. On 10 September 2002 Mrs D submitted the information she believed the Council had asked for. Shortly afterwards, on 20 September, the Council sent to the Trust copies of the external assessors' reports and asked them to provide any comments they wished to make on their content by 27 September. The Trust did not receive the Council's letter until 24 September (it was postmarked 23 September), and telephoned the Council to establish whether the deadline on 27 September was 9.00am or 5.00pm; they were told it was 5.00pm. The Trust sent through their detailed comments by 5.00pm on 27 September. Meanwhile, the committee meeting had already taken place between 10.30am and 3.00pm and had formulated a recommendation to be considered by the full Council. On 1 October, the Trust sought to establish whether the committee had considered the assessor's report alongside the comments they had provided. The Council told them that the committee had not had the Trust's comments, as they had not been received in time. However, they would be considered by the full Council when it met on 11 October. The Council decided to reject the application, as recommended by the committee, on the basis that the Trust had been unable to demonstrate the long term financial viability of the project.

The Trust contacted the Council and indicated that they wished to appeal, on the basis that the council had not followed their own Code of Best Practice (the Code), and that the mishandling had materially affected the consideration of the Trust's application. In advance of an appeal hearing scheduled for 12 December, Mrs D made a number of requests for information, including a request for a copy of the Council's submission to the appeal panel which provided their response to the Trust's complaint.

In early December, the Council provided some of the documents requested, but not the Council's submission (this was not released to the Trust until after the appeal

hearing took place on 12 December). Mrs D also asked for a copy of the minutes of the appeal hearing and wanted to know whether the panel had accepted any of the Trust's points of appeal.

In mid January 2003, the Chair of the appeal panel told Mrs D that the appeal had been unsuccessful, as the panel had concluded that the Council had followed correct procedures. Mrs D was also told that appeal hearings were not formally minuted, but rather notes were kept as an 'aide memoire' for the panel in reaching their decision; the appeal panel had considered Mrs D's request but did not think it appropriate to release a copy of the notes. Mrs D remained concerned that the Trust's comments had not been considered properly by the Council, and remained concerned that she had not been given an opportunity to see the Council's submission to the appeal hearing in advance. She felt that was unfair, as the Council had clearly seen the Trust's submissions and complaints. However the Council declined to change their position.

Mrs D complained to the Ombudsman that the Council had failed to manage properly the procedures and timetable for consideration of the Trust's application, and had failed to consider the Trust's submissions on the assessors' reports. As a result, the Trust had been denied the opportunity to have their funding application fully and fairly considered.
Mrs D also complained that the Council had failed to explain adequately the reasons for their decision on both the application and subsequent appeal, and that they had unreasonably declined to provide information she had requested about those decisions.

Findings

The Ombudsman identified some shortcomings in the Council's handling of the grant application including the tight timescale given to the Trust for return of their comments on the assessors' reports. However, he was satisfied that the Council's overall intention was to be helpful to the Trust in ensuring their application was considered by the September committee meeting, which was the Trust's preference. He also found that the Council had departed from their own procedures in relation to the external assessment of applications, in that the committee had not considered the Trust's comments alongside the assessors' reports. The Council told the

Ombudsman that they did not feel that this had materially affected the outcome of the application, as the application had to be considered by the full Council because of the financial amount involved. The Ombudsman found that there was no evidence to suggest that the committee's (or Council's) decision would have been any different if they had seen the Trust's comments, and was satisfied that the Council had taken full account of the Trust's comments. The Ombudsman was concerned, however, that the Council had not provided sufficiently detailed reasons for the rejection of the application, and recommended that the Council review their procedures for notifying organisations of funding decisions.

The Ombudsman also found shortcomings in the handling of the Trust's appeal. He concluded that a formal note of the appeal hearing should have been produced, and that if it had been, it would have led to some of the Trust's concerns about the hearing being addressed. He also criticised delays by the Council on providing information Mrs D had requested, and that the Council had failed to keep Mrs D informed of the reason for the delay. He noted that the Council's submission to the appeal panel had in the event, merely been a copy of the speaking notes used by the relevant office and were given to the panel on the day. There was therefore no criticism of the Council for failing to provide Mrs D with a copy in advance.

Remedy

The Council agreed to apologise to the Trust for the shortcomings identified. They also agreed to review their procedures for notifying organisations of grant decisions and appeal panel decisions in order to enhance the clarity of the decision, and the reasons why it was reached. The Council also agreed to review their procedures in respect of the release of information.

4 Report of the Health Service Commissioner for Wales

The Health Service Commissioner for Wales investigates complaints made by members of the public who feel they have suffered because of unsatisfactory treatment or service provided by, or on behalf of, the National Health Service in Wales, including family doctors (GPs), dentists, pharmacists or opticians. In formal terms, the Ombudsman has a jurisdiction to consider complaints of maladministration by NHS bodies which is very similar to that to the Local Commissioner for Wales and the Welsh Administration Ombudsman. However, he also has jurisdiction to consider complaints of service failure and can criticise the actions and decisions of clinical staff, where appropriate, without having to consider whether they amount to maladministration. The Ombudsman will normally draw on the assistance of appropriate professional advisers in considering complaints that have a clinical element (which is the great majority of cases). A panel of advisers is maintained on an England and Wales basis, with costs appropriately shared via a service level agreement with the Health Service Commissioner for England.

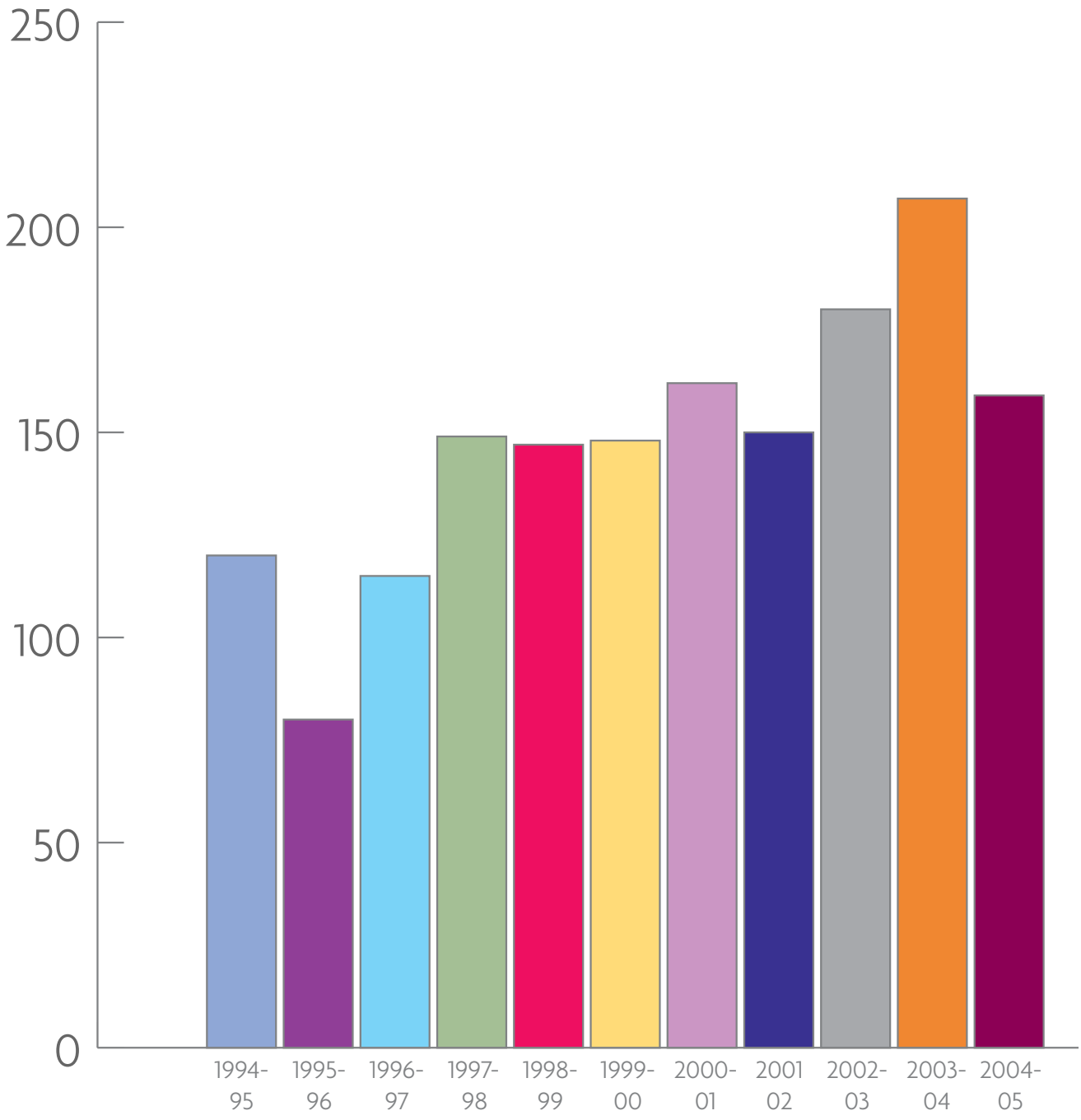
Complaints Received by Year 1994/95 to 2004/05

As illustrated by the graph overleaf, 159 complaints were received in 2004/05 compared to 207 in 2003/04. The difference can be attributed to the significant number of complaints received in 2003/04 relating to long term care, or continuing care as it is commonly known. This upsurge was particularly apparent following a special report published on this matter in early 2003 by Ann Abraham, the then Health Service Commissioner for England and Wales. It is pleasing to note that the number of complaints received in relation to long term care fell during 2004/05. However, my office has undertaken much work in relation to this subject over the past year and I am reporting separately on this in a special section later in this report.

With the fall in the number of cases relating to continuing care, the overall level of complaints received by my office during 2004/05 was consequently more in keeping with the pattern of complaints received over the past ten years.

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

Number of Complaints Received 1994/95 to 2004/05



4

Workload for the Year

Once again, it is cases relating to continuing care that largely account for the differences in overall workload between 2003/04 and 2004/05. The overall total screening workload decreased in a manner consistent with the decrease in continuing care complaints. In particular, it can be seen from the table below that only 6 of these were referred back or sent to the relevant body in 2004/05, compared to 54 in the previous year.

Details of Workload for the Year

Screening work	Complaints and Enquiries brought forward Complaints received Enquiries received Total Screening Workload
Outcomes	Continuing Care cases referred back or sent to relevant body Enquiry answered Not in jurisdiction No action required /No formal action Referred back and closed Premature - local action not exhausted Advice given to relevant body Further action agreed by relevant body Decision to conduct investigation
Total Screening Decisions Taken Screening cases carried forward	
Investigation work	Investigations brought forward New investigations begun
Total investigations completed **Investigations carried forward**	

The very low, or non-existent, number of cases in 2004/05 that come under the category 'advice given to relevant body' and 'further action agreed by relevant body' is as a result of a change in procedures in September 2004. Such cases are now included under investigation work, rather than screening work. This change also partly accounts for the higher level of investigation work seen in 2004/05.

2004/05	2003/04
19 159 21 199	35 209 23 267
6 23 10 20 8 51 1 0 43	54 21 11 43 6 57 6 4 47
162 37	248 19
49 43	13 47
45 **47**	**11** **49**

Health Body	Decision to conduct investigation		Further action agreed investigation by health body		
	04/05	03/04	04/05	03/04	
Bro Taf Health Authority					
Cardiff Local Health Board		2			
Vale of Glamorgan Local Health Board		1			
Merthyr Tydfil Local Health Board					
Rhondda Cynon Taff Local Health Board	1	1			
Dyfed Powys Health Authority				1	
Carmarthenshire Local Health Board					
Ceredigion Local Health Board		1			
Pembrokeshire Local Health Board					
Powys Local Health Board	6	1			
Gwent Health Authority					
Blaenau Gwent Local Health Board					
Caerphilly Local Health Board					
Monmouthshire Local Health Board					
Newport Local Health Board	1	1			
Torfaen Local Health Board					
Iechyd Morgannwg Health					
Bridgend Local Health Board					
Neath/Port Talbot Local Health Board		2			
Swansea Local Health Board				1	
North Wales Health Authority		1			
Anglesey Local Health Board					
Conwy Local Health Board					

	Advice given to to relevant body		Continuing care cases referred back or to relevant body		Other cases resolved		Total Complaints	
	04/05	03/04	04/05	03/04	04/5	03/04	04/05	03/04
				2		2		4
				3	3	1	3	6
				3				4
				1		1		2
				1	5	1	6	3
				2				3
								0
					1		1	1
				1				1
			2	2	7	2	15	5
				1	1	3	1	4
				1	2		2	1
				1	1	2	1	3
				2	2		2	2
			1	1	2		4	2
				1	1		1	1
								0
			1	4		1	1	5
				2	2		2	4
				2		1		4
				3		1		5
								0
				5				5

Health Body	Decision to conduct		Further action agreed investigation by health body		
	04/05	03/04	04/05	03/04	
Gwynedd Local Health Board					
Denbighshire Local Health Board					
Flintshire Local Health Board		1			
Wrexham Local Health Board					
Bro Morgannwg Trust	3				
Cardiff & Vale Trust	4	3			
Carmarthenshire Trust					
Ceredigion & Mid Wales Trust		1			
Conwy & Denbighshire Trust	1				
Gwent Healthcare Trust	4	8			
North East Wales Trust	3	1		1	
North Glamorgan Trust		2			
North West Wales Trust	3				
Pembrokeshire & Derwen Trust	3	2			
Pontypridd & Rhondda Trust		1			
Swansea Trust	2	1			
Velindre Trust					
Welsh Ambulance Services Trust					
Complaints procedure 2nd Stage		9			
GP	10	14			
Dentist					
Other	2				
None/Unknown					
TOTAL	**43**	**53**	**0**	**3**	

	Advice given to to relevant body		Continuing care cases referred back or to relevant body		Other cases resolved		Total Complaints	
	04/05	03/04	04/05	03/04	04/05	03/04	04/05	03/04
				2				2
			1	3			1	3
				4	1	1	1	6
				3	1		1	3
				1	2	3	5	4
					11	20	15	23
					5	2	5	2
					1	4	1	5
				1	7	3	8	4
	1	2			18	7	23	17
					5	4	8	6
		1			4	3	4	6
					5	3	8	3
					4	4	7	6
					3	2	3	3
					9	10	11	11
		1			1	1	1	2
						1		1
								0
						1		10
		2			14	11	24	27
						4		4
			1		6		9	0
				3	22	12	22	15
	1	**6**	**6**	**55**	**146**	**111**	**196**	**228**

Summaries of Cases

Carmarthenshire NHS Trust & Swansea NHS Trust.

Mr D complained that he was admitted to West Wales General Hospital in February 2000 complaining of a cough, breathlessness, night sweats and a fever. A provisional diagnosis was made of pleural effusion (fluid in the space between the lungs and the chest wall) due to pneumonia, and antibiotic treatment was begun. Following some improvement in his condition, Mr D was discharged. He was subsequently referred to a consultant surgeon at Morriston Hospital in Swansea, who advised that he should undergo an operation to remove the thickened pleura which had developed as a result of his illness and had reduced his lung capacity. Mr D stated that the consultant told him that this operation had to occur within the next month or two for the maximum chance of success; however, he said he also told him that he would need to wait 12-14 months on the waiting list. Mr D said that this caused him considerable anxiety, and he consequently paid £5,500 to have the operation carried out privately by the consultant surgeon. Samples of the pleura removed during the operation revealed that Mr D had tuberculosis. Mr D complained to the Ombudsman that his condition was inadequately investigated at West Wales Hospital, which led to his diagnosis and treatment being delayed. Mr D also complained that the consultant surgeon at Morriston Hospital unreasonably influenced him to have private treatment.

The Ombudsman found that the type and presentation of Mr D's illness (an acute tuberculous effusion) was rare. He did not therefore uphold the complaint against Carmarthenshire NHS Trust for not making the correct diagnosis at an earlier stage. The Ombudsman did, however, uphold the complaint against Swansea NHS Trust. While the Ombudsman did not believe there was evidence to suggest that the consultant surgeon had deliberately set out to mislead Mr D, he felt it was unlikely that he had communicated the options available to Mr D as well as should have been the case. The consultant surgeon had been the sole channel of communication between Swansea NHS Trust and Mr D about the treatment options open to him. The Ombudsman commented that the surgeon needed to take particular care in communication as he stood to gain financially if Mr D opted for private treatment.

The Ombudsman found that this failure in communication amounted to maladministration on the part of the Trust and recommended that Swansea NHS Trust reimburse Mr D the cost of his private surgery. He also recommended that the consultant surgeon should review his record keeping in the light of concerns which had been identified during the course of the investigation. The Ombudsman's recommendations were accepted by the Trust.

North Glamorgan NHS Trust

Mrs N complained to the Ombudsman about the arrangements for her late husband's discharge from hospital, following his admission with an exacerbation of chronic obstructive pulmonary disease. In particular, she complained that there was a failure to acknowledge Mr N's mobility problems; a failure to follow up concerns she raised after his discharge; and a failure to follow through a recommendation for day hospital support. She also complained that her husband's medical records, a copy of which she obtained after his death, were inadequate.

The Ombudsman found there was evidence of poor communication in this case, which meant that when Mr N arrived home, his wife, who is herself disabled, had to care for him without adequate instructions or assistance. When she telephoned the hospital for advice, she was unable to get any, as Mr N had been discharged on a Friday afternoon, and did not arrive at home until after 5.00pm. Although it had been identified that Mr N would need his bed to be moved downstairs, and that he required an oxygen concentrator, these requirements were not followed up. Consequently, Mr N, who could no longer manage the stairs, had to sleep on the sofa. Neither Mr nor Mrs N appear to have been made aware that a day hospital appointment was to be arranged.

The Ombudsman also found that Mr N's health records were not of an acceptable standard. A number of documents, including the discharge planner, were absent, and certain aspects of Mr N's care did not appear to have been adequately recorded in the nursing notes. There seemed to be a lack of awareness of acceptable standards of record keeping on the part of some of the staff who were interviewed during the

course of the investigation, and it was acknowledged that due to unfamiliarity, the charts used in the ITU department are sometimes thrown away by members of staff who did not know what they were for.

The Ombudsman upheld Mrs N's complaints. He made a number of recommendations aimed at improving record keeping and communication which were accepted by the Trust.

Neath Port Talbot Local Health Board

Mrs D complained that she had approached Neath Port Talbot Local Health Board (LHB) to request a review of her father, Mr A's, past eligibility for continuing care funding. However, the LHB told her that they could not carry out the review on the grounds that Mrs D does not hold an enduring power of attorney for Mr A (who lacks the mental capacity to grant one), nor has she been appointed as receiver by the Court of Protection to manage his affairs. Mrs D argued that it was unfair of the LHB to require that she obtained a grant of receivership before they would consider her request as applying for this could involve considerable expense, and potentially be fruitless, were Mr A found not to be entitled to funding.

The Ombudsman found that the LHB were entitled to require that Mrs D obtain the appropriate authority before they would carry out a retrospective assessment, as otherwise they could be in contravention of the Data Protection Act 1998. While this Act does allow for an individual's medical records to be accessed without consent for "medical purposes", the Ombudsman agreed that a request for retrospective review of entitlement to continuing care funding would not fall within this definition, as it would not in any way affect the care that Mr A was currently receiving. The Ombudsman appreciated that, in terms of natural justice, this might seem unfair, as Mr A could, potentially, have lost a considerable sum of money; however, there was no scope within the law as it stands for an assessment to be carried out without the appropriate authority. However, in view of the issues raised by Mrs A's complaint, the Ombudsman suggested that Powys LHB should consider reviewing the guidance it provides to other LHBs about handling retrospective review claims in order to make this point clear.

A GP in the Caerphilly Local Health Board Area

Mr and Mrs K complained to the Ombudsman about the standard of care and treatment provided by the GP to Mrs K's late father, Mr W, between December 1998 and his death in October 1999. In particular, Mr and Mrs K complained that the GP was reluctant to visit and examine Mr W, and did not take appropriate steps to manage his ill health. Mr W suffered from a number of health problems, principally chronic obstructive airways disease, and had previously suffered a stroke. It appears that during the last year of his life, Mr W was bed-bound.

The GP was unable to remember the events complained about, and it was found that his records relating to Mr W were minimal, despite Mr W's poor health. It was not therefore possible to resolve whether the GP had refused to visit Mr W or not. However, the standard of the GP's record keeping was sufficiently poor to suggest that the care and treatment provided to Mr W was, on the balance of probability, of an unacceptable standard. The Ombudsman upheld the complaint. He did not make any recommendations, as the GP had told his investigator that he had retired from practice. The Ombudsman subsequently learnt that this was not the case, and the GP was, in fact, practising in England. When the GP was contacted by the Ombudsman's office and his attention was drawn to the potentially severe consequences of giving misleading evidence to the Ombudsman, he apologised for any misunderstanding on his part, and initially agreed to retire permanently from practising as a GP. He subsequently contacted the Ombudsman's office to ask if he might practice again after a significant programme of retraining. The Ombudsman agreed to this.

Gwent Healthcare NHS Trust

On 29 August 2002 Mr D was admitted to Neville Hall Hospital under the care of a Consultant Physician, complaining of rectal bleeding. Within a few hours of admission Mr D vomited a quantity of blood. After about 16 hours, he was given a blood transfusion and a quantity of saline. On 30 August an endoscopic examination was performed by a specialist registrar who worked under a Consultant Gastroenterologist which indicated diverticular disease. On 6 September Mr D was discharged home. Mr D was told by a Senior House Officer (SHO) working for the Consultant Physician that the rectal bleeding was unlikely to recur. The SHO indicated that Mr D did not require a follow-up appointment; he indicated a provisional diagnosis of angiodysplasia and

diverticular disease. In November, Mr D and his wife visited their holiday home in Spain. Whilst there, Mr D suffered another episode of rectal bleeding and was also vomiting blood and, therefore, was taken to hospital; sadly Mr D died five days later. Based on the tests and scans undertaken whilst at the Spanish hospital, the clinicians treating Mr D attributed the cause of death as oesophageal varices secondary to liver cirrhosis.

Mrs D complained to the Trust about its failure to diagnose, treat and follow up on her husband's condition. She believed that her husband should not have been discharged without a firm diagnosis or follow up. Mrs D also questioned the experience of the specialist registrar who performed the endoscopies on her husband.

The Ombudsman's Professional Assessor concluded that the care Mr D received during the first 24 hours of his admission to Neville Hall hospital was unsatisfactory; guidelines to junior doctors were not followed, blood transfusion arrangements were inadequate; cardiovascular monitoring was not optimal. The Assessor also concluded that on balance the endoscopy the day after Mr D's admission was performed by an inexperienced endoscopist and that the Consultant gastroenterologist was not present. The Assessor also noted that there had been no discussion of Mr D's diagnosis at consultant level, and that he should not have been discharged from hospital without a planned follow-up. Based on information obtained during the course of the investigation the Ombudsman also formed the view that the Trust had, at best, been disingenuous in the responses it had provided to Mrs D.

The Ombudsman, mindful of his assessor's view that the overall care at the hospital was unsatisfactory, upheld the complaint in its entirety. The Trust apologised to Mrs D for the failings that had been identified. They agreed to put in place a clear structured set of guidelines for identifying and managing patients who present with gastrointestinal haemorrhage. The Trust also agreed to ensure that the care of such patients are transferred to a gastroenterologist at the earliest opportunity. The Trust also agreed to implement to implement guidelines set out by the British Society of Gastroenterology to ensure that patients such as Mr D are operated upon by

experienced staff. The Trust also agreed to implement policies to minimise the risks to hospital staff and patients as a result of the workload to which Trust staff are subjected. The Trust also agreed to review its procedures to ensure that responses to complainants are fully investigated and reported accurately in a manner which is consistent with the views of its own staff.

Two General Practitioners in the area of Gwynedd Local Health Board

Mr and Mrs C complained that they took their baby son to see their GP (the first GP) on two separate occasions complaining of a rash. On the first occasion the GP diagnosed an allergic response to an antibiotic that he had previously prescribed. When he saw the baby again two days later the first GP, on this occasion diagnosed eczema. Mrs C believed that on both occasions the first GP had failed to examine her son properly and that as a consequence he had failed to identify or act upon what Mrs C felt to be clear signs of meningitis.

Later that evening and through to the following Sunday morning, the baby's condition deteriorated to such an extent that Mr and Mrs C felt compelled to call the out of hours doctor (the second GP) at around 8.00am to ask him to examine the baby. Mr C outlined the symptoms over the telephone but second GP told Mr C to bring the baby to their local GP practice by 10.30 and that he would examine him there. Mr and Mrs C, given the severity of the baby's condition, felt that it was not safe to wait this long and therefore decided to take their son directly to their nearest general hospital.

Upon arrival at the hospital, the baby was admitted where he received treatment for suspected meningitis for nine days before he was discharged home.

The Ombudsman's Professional Assessors stated that because of the "worrying lack of detail" in the first GP's records they were unable to determine whether he undertook appropriate examinations of the baby on the two occasions. The Assessor concluded that the approach taken by the first GP was not unreasonable although they felt that the first GP's management of the baby's antibiotic treatment whilst not necessarily wrong, would have differed from that of most GPs. The Ombudsman was unable to reach a finding on whether the examinations conducted by the first GP was adequate.

However the Ombudsman upheld the complaint to the extent that the first GP did not maintain a satisfactory standard of record keeping.

With regard to the actions of the second GP, the Ombudsman's Professional Assessors were of the view that whilst the second GP could have taken additional steps to diagnose the baby's condition, they did not consider that this shortcoming on its own meant that his actions fell below the standard that could reasonably be expected of a GP in his position. The Ombudsman concluded that there had been a breakdown in communication between the second GP, however he was reassured by the second GP's commitment to question patients more thoroughly in future in order to establish the fullest possible patient history.

Finally, during the course of the investigation it came to the Ombudsman's notice that the first GP's practice did not have a practice based complaint procedure as required by guidance on the NHS complaints procedure.

The first GP agreed, in future, to follow the guidance produced by the General Medical Council on maintaining medical records. The first GP has also put in place a practice based complaints procedure. The second GP undertook to ensure, when he considers similar requests to see patients in future, to consider all the options available to him,

Long Term Care

I have had cause to be particularly concerned about the number of complaints I have received in relation to long term care and much work has been undertaken by my office in relation to this matter. Accordingly, I consider that it is appropriate to give this aspect of activity separate and special attention in this year's report.

Background

NHS funded long term care, or continuing care as it is more commonly known, is a package of care arranged and funded solely by the NHS for people who need it because of disability, accident or illness. It can cover physical and mental health needs and can be provided in a range of settings, such as care homes, patients' homes or hospitals.

For some time, there has been concern about the criteria applied by NHS bodies when assessing eligibility for continuing care funding. In particular, Ann Abraham, the Health Service Commissioner for England, issued a major report on the subject in early 2003 (when she was also Health Service Commissions for Wales). The reports findings and recommendations were directly relevant to Wales.

As a result, in April 2003, the Welsh Assembly Government asked local health boards to review whether the continuing care criteria in use since 1996 were compliant with the law. At that time too, a great number of people approached their local health boards asking for their entitlement to continuing care funding to be reviewed. Subsequently, many approaches and complaints were made to my office by people concerned about the delays they were experiencing following their application for a review.

I therefore decided to investigate a sample number of cases to find out why those delays were occurring. In order that my investigations might consider the role of all the official bodies involved in that procedure, I undertook to examine the part played by the Welsh Assembly Government, Powys Local Health Board (which was given an all-Wales role in such matters) and whichever local health board was dealing with the specific case in question.

Long Term Care Entitlement: Retrospective Reviews

As my enquiries progressed, it became apparent that many local health boards had received requests for retrospective reviews which they were unable to determine because of the lack of guidance and instructions from the Assembly at a sufficiently early stage (Case Study 1 exemplifies this). I was aware that local health boards were also facing problems in obtaining the necessary evidence and records on which to base a retrospective determination. Even when the records could be located and obtained, many examples came to light where the patient had originally entered care from hospital without evidence of the requisite discharge planning or consultation with family and carers, as set out in WHC(95)7 NHS Responsibilities for Meeting Continuing Care Needs having taking place. The lack of such contemporary assessment of a patient's entitlement to continuing care funding undoubtedly made it harder for those seeking to review past entitlement to determine the precise circumstances that existed at the time the person first entered care. I have not, as a general rule, chosen to investigate failures in the original discharge procedures as it seems to me that further exposing any shortcomings in that regard would not assist those now charged with determining a person's past entitlement to funding. Nevertheless, the fact that those failures occurred, and might now potentially jeopardise successful claims for retrospective entitlement, is most unsatisfactory.

Case Study 1

Mr J's mother (Mrs J) was admitted to a care home in 1996 when her deteriorating dementia and extreme behaviour made it unreasonable for her to remain at home. Although, social workers assisted Mr J to find a suitable care home for his mother he was unaware that his mother might be entitled to long term NHS care until he learnt of Ann Abraham's report. In April 2003, Cardiff Local Health Board agreed to his request to fund his mother's current entitlement and to consider the issue of arrears from 1996. In October 2003, Mr J complained to me about the delay in trying to resolve that matter. I found that while Cardiff Local Health Board had taken appropriate action to determine and fund Mrs J's ongoing care they could not determine her entitlement to arrears as they were still waiting for guidance, promised

by the Assembly in April 2003, about how to deal with such claims. Indeed, instructions provided by the Assembly in October 2003 advised LHBs not to decide those claims until it had made suitable arrangements to provide an all-Wales process to deal with retrospective claims. I noted that although legislation produced by the Assembly in February 2003 confirmed that Powys Local Health Board was responsible for pre April 2003 liabilities, it had taken until the Autumn of that year for the Assembly to ask Powys Local Health Board to manage an all-Wales process for determining retrospective continuing care entitlement. I criticised the dilatory nature of the Assembly's role in determining those arrangements and producing suitable guidance but felt that Powys Local Health Board had acted satisfactorily in taking that project forward. I also recommended that both bodies should issue further guidance to ensure that all cases, where injustice might have occurred, were identified.

Often, by the nature of their need for care in the first place, many patients currently in care are not, on their own, in a position to ask for a review of their entitlement to continuing care to be done. It is also the case that many of the patients who, if they had been properly assessed while in care may have benefited from continuing care funding, have since died. While in many cases their relatives or the executors of their estates have now come forward to ask for a review, it still concerns me that to date the emphasis in Wales, partly, I accept because of the pressure already on local services to review cases, has been on determining only those cases that have been specifically drawn to the attention of local health boards. It was because of those concerns that I chose to remind the relevant bodies to ensure that measures would be taken to satisfy Ann Abraham's recommendation to identify all patients in their areas who may have been disadvantaged by unfair or wrongly applied criteria.
I have welcomed the fact that subsequently the Welsh Assesmbly Government undertook an advertising campaign during the Spring of 2005 to encourage potential claimants to come forward. However, I remain concerned that, particularly where the patient might have died, there will still be a number of potential beneficiaries of continuing care funding who will still be unidentified.

However, even where individuals have come forward to request a review on behalf of a relative, the process of determining their claim has not always been straightforward. While, I recognise the importance of local health boards ensuring that those seeking a review have due title to act for the person in care, it is clear that more guidance is

required to assist them to administer such cases to ensure that those who may have underlying entitlement to help from the NHS for their care do not lose out. Guidance on how that title should be established seems to me to be particularly relevant in light of the campaign to advertise the availability of continuing care funding and encourage further claims. It is no good asking for people to come forward unless the issues surrounding title, and how that affects a local health board's ability to process a claim, are addressed. The following case dealt with such issues.

Case Study 2

Mrs D complained that she had approached Neath Port Talbot Local Health Board (LHB) to request a review of her father, Mr A's, past eligibility for continuing care funding. However, the LHB told her that they could not carry out the review on the grounds that Mrs D does not hold an enduring power of attorney for Mr A (who lacks the mental capacity to grant one), nor has she been appointed as receiver by the Court of Protection to manage his affairs. Mrs D argued that it was unfair of the LHB to require that she obtained a grant of receivership before they would consider her request as applying for this could involve considerable expense, and potentially be fruitless, were Mr A found not to be entitled to funding. The Ombudsman found that the LHB were entitled to require that Mrs D obtain the appropriate authority before they would carry out a retrospective assessment, as otherwise they could be in contravention of the Data Protection Act 1998. While this Act does allow for an individual's medical records to be accessed without consent for "medical purposes", the Ombudsman agreed that a request for retrospective review of entitlement to continuing care funding would not fall within this definition, as it would not in any way effect the care that Mr A was currently receiving. The Ombudsman appreciated that, in terms of natural justice, this might seem unfair, as Mr A could, potentially, have lost a considerable sum of money; however, there was no scope within the law as it stands for an assessment to be carried out without the appropriate authority. However, in view of the issues raised by Mrs A's complaint, the Ombudsman suggested that Powys LHB should consider reviewing the guidance it provides to other LHBs about handling retrospective review claims in order to make this point more clear.

I understand that since I issued it, the report summarised above was circulated by Powys Health Board to all local health boards in Wales to ensure that they are aware of the issues raised. I have also seen other examples where the issue of title to continuing care funding arrears has been confused. I have found that some other Local Health Boards have taken, what at first sight, appears to be a more pragmatic approach, in that they have set about processing the review in good faith as to the claimant's title in order to establish first, if there is any entitlement to funds. That too has not been without difficulty, not least in regard to the legal rights, and restrictions, that exist in obtaining and assessing the required medical records and personal information. In some cases the issue of due entitlement to arrears has not fully been addressed until payment of arrears is due, or, as in the following example, until after payment of arrears has been made.

In all Welsh cases, regardless of whether the patient is currently in care or died following a period in care, requests for a review of continuing care entitlement should be made initially to the local health board responsible for the area from which the person entered care. If that patient is currently resident in care, arrangements can readily be made for a local health board representative to visit them to carry out a comprehensive assessment of their needs against the relevant eligibility criteria in order to determine whether or not they are entitled to have their care funded by the NHS. It is important to mention here that in this context continuing care funding would mean that the person's care needs, irrespective of their individual means or assets, would be met entirely from NHS funds. Those who are not entitled to full continuing care funding may, dependent on their individual circumstances, be entitled to another form of payment known as NHS funded nursing care. This is a fixed monetary sum which can be paid by the NHS to cover the cost of care provided by a registered nurse to a patient who is resident in a care home that provides nursing care as part of a package of care.

If following an assessment it is agreed that the patient is entitled to full continuing care funding, the responsibility for paying for that patient's care falls entirely to the relevant local health board, who will need to make arrangements for regular payments to the care home; and reimburse any arrears (if necessary back to the date the LHB itself came into being). Not surprisingly many of the cases that were put

forward for review involved patients who had been in care before 1 April 2003 when local health boards replaced health authorities. Some of those patients had died before 1 April 2003 or since. It was specifically in order to determine entitlement, and where appropriate award arrears for pre April 2003 continuing care funding that the Special Review process was developed. The process was instigated by the Welsh Assembly Government and is currently managed on an all-Wales basis by Powys Local Health Board. In keeping with Ann Abraham's original recommendations, the Special Review Panel can consider and award arrears dating as far back as April 1996.

The guidance on the arrangements to review pre-April 2003 continuing care funding was issued to individual local health boards by Powys Local Health Board in early 2004. It makes each local health board responsible for the local investigation and initial assessment of each claim for pre April 2003 funding, but the Special Review Panel has the final say on whether or not an individual is entitled to continuing care and to any arrears.

I am aware that there is often a considerable amount of work done and lot of time spent by local health board officials preparing each case for referral to the Special Review Panel. I am also aware that in order for the Special Review Panel to function effectively it is important that each referring local health board provides accurate and comprehensive background papers on which the Special Review Panel may make its decision. Only through good practice by both will the procedure be effective. The procedure laid down by Powys Local Health Board also encourages the referring local health board to carry out its own initial assessment of entitlement and for that to result in recommendation on entitlement to be submitted to the panel. However, the Special Review Panel is not bound by that recommendation and may, if it thinks fit, award continuing care funding even if the referring local health board has recommended otherwise.

The Special Review Panel procedure also encourages claimants to attend the panel hearings and if they so wish, allows them to directly address the panel. I know that some may find such a proposition daunting, but I feel that that opportunity to present one's own case is something that many claimants will value and welcome.

Nevertheless, I have now received a number of complaints from some claimants expressing concern about the way the Special Review Panel process itself is being conducted and, therefore, this will be another aspect of long term care that I will be investigating over the next year.

Financial Recompense

Not all the people whose claims to continuing care funding have been met have been fully satisfied. I made it clear in the report of my own first investigation into continuing care following Ann Abraham's report that further consideration needed to be given to the award of interest. I am acutely aware that the financial burden on those entering care, or on their families, is a great one. As the law stands there is no across the board requirement for the cost of that care to be met by the public purse, but there is, and has been for many years, a requirement for the NHS to fund the care of those who need it by virtue of disability, accident or illness.

While it is reasonable for public bodies to set criteria upon which entitlement to public funds may be determined, it seems to me that many of those who have now come forward, or for whom others now act, and who have had their claims met, should have previously been identified and properly assessed under the procedures regarding long term care that have existed since 1996. Maladministration in operating those procedures has undoubtedly denied many individuals funds to which they were legally entitled. As a result many individuals and their families have suffered financial hardship. It is, therefore, absolutely proper that any arrears now awarded should be paid with adequate recompense for loss of interest.

My general view is that where people have been denied money to which they were legally entitled, interest should be paid at the County Court rate. At the end of the year being reported on, I was concerned that Powys LHB was only paying interest equivalent to the Retail Price Index (RPI) and asked Powys LHB and the Welsh Assembly Government to consider payment of interest at the County Court rate.

In subsequent discussions, the Welsh Assembly Government told me that the use of the RPI interest rate mirrored practice in England. The decision to pay interest at the

RPI rate there had been taken in the light of a formal decision by the Department for Work and Pensions (DWP) not to reclaim benefits from successful claimants for retrospective NHS continuing care payment. At my suggestion, the Welsh Assembly Government secured a formal written statement from the DWP that the decision not to reclaim benefits applied in Wales as it did in England. I am now satisfied that receipt of interest at RPI rate without having to repay benefits is at least as favourable to the great majority of claimants as payment of interest at the County Court rate would have been.

I was also concerned about the form of indemnity, which claimants are required to sign on receiving payment of arrears. Some aspects included on the form of indemnity, such as the requirement for a signed undertaking not to pursue any further claims (known or unknown, actual or contingent) against Powys Local Health Board, seemed to me to be unnecessary and somewhat overbearing.

Powys Local Health Board have subsequently agreed to introduce a revised form of indemnity which I consider to be reasonable.

Other Developments

On 31 August 2004, the Welsh Assembly Government issued a circular on NHS Responsibilities for Meeting Continuing NHS Health Needs (WHC (2004)54; NAFWC 41/2004) which replaced previous circulars and guidance on continuing care. The guidance was accompanied by the document; Continuing Care NHS Health Care: Framework for Implementation in Wales. That framework was intended to provide a basis for the implementation of the guidance across Wales and to provide a common foundation for local decision-making and delivery of continuing NHS healthcare across Wales, to ensure that there was a consistent, equitable and appropriate application of the eligibility criteria. The guidance sought to address the issues raised in relation to the provision of continuing NHS care by Ann Abraham's report, and by a number of legal judgements, including the 1999 Court of Appeal judgement, referred to as the Coughlan judgement. It asked local health boards (repeating a request made by the Director of NHS Wales in April 2003), to confirm, within three months of the issue of the guidance, that their continuing care health care policies reflected the outcome of the Coughlan judgement and Ann Abraham's report.

Whilst I welcome the production of the guidance and framework produced by the Welsh Assembly Government in relation to the assessment of eligibility for NHS funding of continuing care, they do not to my mind clearly introduce a single set of criteria upon which all applications for continuing care made in Wales will be determined. While local plans may need to vary slightly because of local circumstances, the Welsh Assembly Government should, in my view, issue a single recognised set of eligibility criteria that all local health boards are expected to use in order to ensure equality of treatment across Wales. This will be a matter that I will again raise with the Welsh Assembly Government during 2005/06.

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

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

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