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Consultation response

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

Organisation name: Senedd Cymru: the Finance Committee

Submitted: 28 March 2025

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

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

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

Foreword

Thank you for the opportunity to respond to this inquiry.

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

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

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

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

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

This is legislation that Wales can be proud of.

Summary

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

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

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

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

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

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

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

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

As an office, we can:

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

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

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

Terminology

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

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

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

Data and research informing this submission

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

Our casework and equality data

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

Complaints standards data

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

Data on our financial performance

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

Wales Omnibus Survey

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

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

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

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

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

Stakeholder Research

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

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

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

Our general work

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

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

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

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

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

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

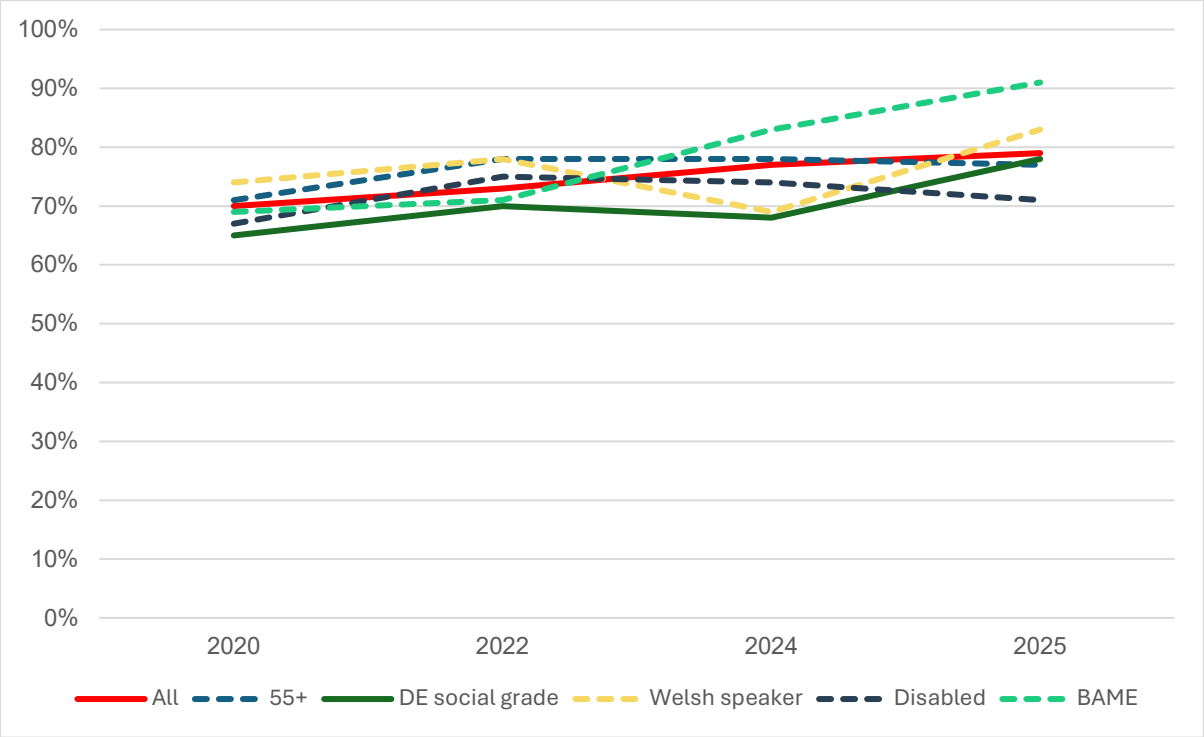
Perceptions of our integrity and impact

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

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

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

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



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

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

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

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

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

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

Areas for improvement

The Statutory Bar - Alternative Legal Remedy

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

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

Education – school complaints

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

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

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

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

2. Complaints other than in writing

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

Background

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

How we have used this power to date

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

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

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

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

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

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

Figure 2: Complaints other than in writing in numbers

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

Our impact

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

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

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

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

Complaint reference 202302069

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

Complaint reference 202100256

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

Complaint references 202105382 & 202303340

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

[1] Who shared their equality information with us.

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

Complaint reference 202405062

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

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

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

Areas for improvement

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

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

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

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

3. Investigations on own initiative

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

Background

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

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

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

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

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

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

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

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

We must

- have regard to the public interest in beginning an investigation

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

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

- have regard to our published Criteria.

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

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

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

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

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

3.1. Wider investigations

How we have used this power to date

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

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

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

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

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

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

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

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

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

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

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

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

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

Our impact

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

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

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

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

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

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

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

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

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

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

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

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

Areas for improvement

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

The process

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

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

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

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

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

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

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

The recommendations

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

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

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

Investigated organisations

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

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

Third sector engagement

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

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

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

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

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

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

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

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

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

5. Increase publicity about the own initiative power.

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

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

3.2. Extended investigations

How we have used this power to date

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

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

Complaint reference 202002273

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

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

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

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

We recommended that the Health Board:

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

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

Complain reference: 202207320

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

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

Complaint reference 202205146

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

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

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

Complaint reference 202202525

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

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

Our impact

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

Complaint reference 202205543

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

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

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

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

Mr D told us:

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

Complaint reference 202005941

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

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

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

Mrs E told us:

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

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

4. Power to investigate private medical treatment

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

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

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

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

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

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

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

5. Complaints standards work

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

Background

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

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

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

How we have used this power to date

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

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

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

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

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

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

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

Our impact

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

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

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

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

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

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

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

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

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

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

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

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

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

Figure 4: Our complaints standards data: local councils

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

Figure 5: Our complaints standards data: Health Boards

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

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

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

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

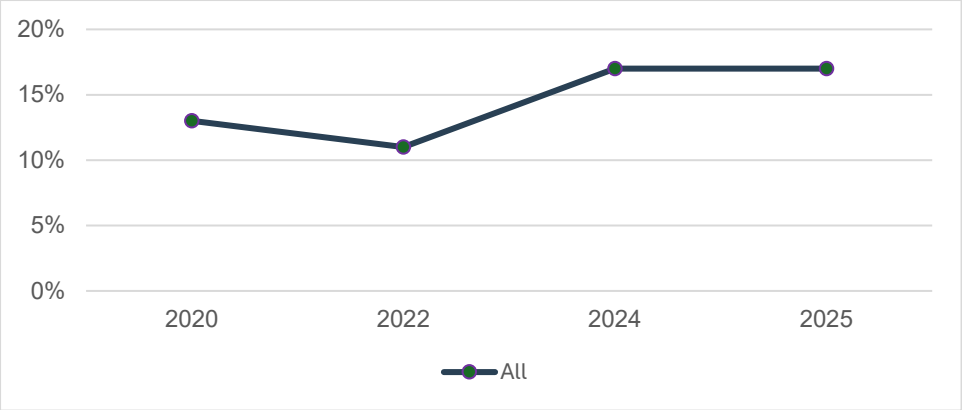


Figure 7: Proportion of respondents who complained and said that it was easy to make a complaint.

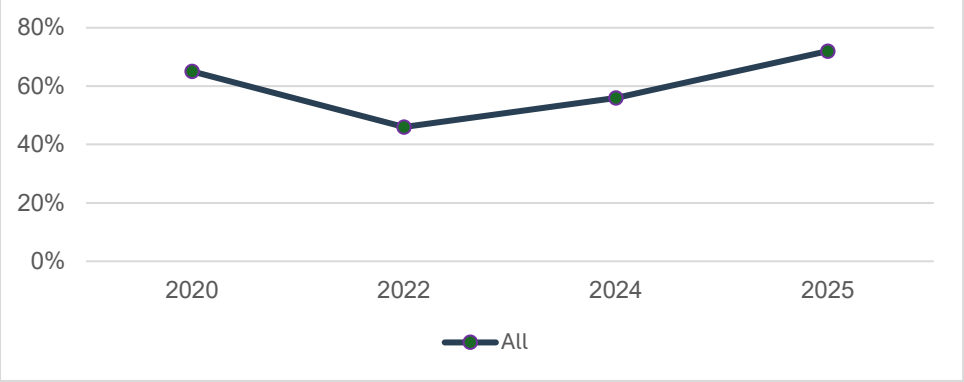
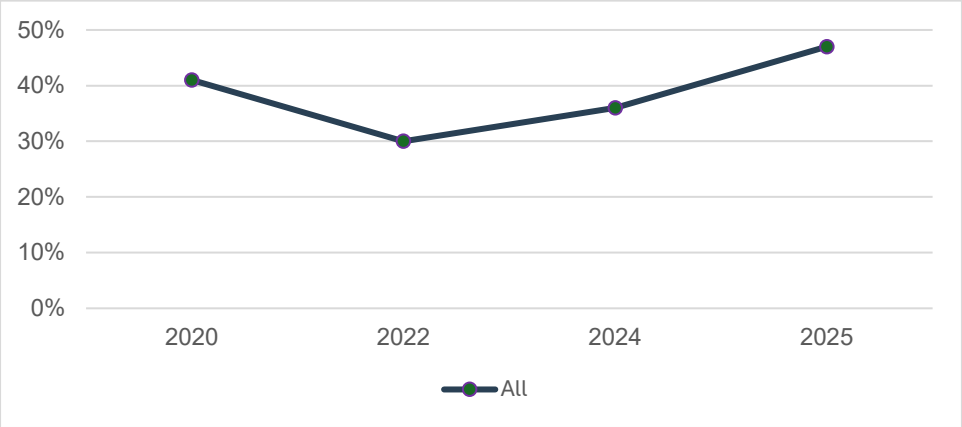


Figure 8: Proportion of respondents who complained and were happy with the way the complaint was resolved.



Areas for improvement

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

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

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

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

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

6. Our Act and the broader ombudsman sector

How the Act compares with current best practice.

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

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

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

Neither England nor Scotland can undertake own initiative investigations.

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

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

7. Policy objectives of the 2019 Act

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

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

- **Improve social justice and equal opportunities**

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

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

- **Protect the most vulnerable**

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

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

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

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

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

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

- **Being more responsive to the citizen**

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

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

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

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

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

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

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

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

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

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

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

8. Cost and benefits and value for money

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

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

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

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

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

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

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

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

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

Michelle Morris

Public Services Ombudsman for Wales

March 2025

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

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