Ombwdsmon
Ombudsman
Cymru · Wales

Ask for: Complaints Standards
01656 641150
Caseinfo@ombudsman.wales

Date: 17 September 2026

Mr Jonathan Morgan
Chair
Cwm Taf Morgannwg University Health Board

By email only
CTM_BoardMember@wales.nhs.uk

Dear Jonathan

Annual Letter 2025-26

Our role

As the Public Services Ombudsman for Wales, we independently consider complaints about public services and investigate alleged breaches of the councillor Code of Conduct. We also set complaints handling standards for public bodies, drive continuous learning from complaints and undertake investigations into public services on our own initiative.

Purpose of this Annual Letter

This letter provides an update on our work for this period, and highlights key trends in Welsh health and public service complaints. It details performance specific to your organisation and outlines the positive actions we would like you to take.

Overview - a record-breaking year

This letter, as always, coincides with the publication of our Annual Report, which holds special significance this year as we mark our 20th anniversary. We closed our busiest year on record where the office received 4,507 duly made complaints across its public services and Code of Conduct remits — 27% more than last year, 47% more than 3 years ago, and 3 times as many as 20 years ago.

To meet this demand, we closed a record number of complaints, 29% more than last year and 43% more compared with 3 years ago. We intervened in 568 of complaints that we closed.

ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

Finding swift resolutions to complaints, where possible, remains important to us and benefits all parties involved. This year, 85% of our interventions included an element of Early Resolution, a process we hope has proved valuable to both your organisation and to complainants.

Despite the increased volume of cases, our case handling times remained efficient. Initial assessments and Early Resolutions were completed within 4 weeks - well ahead of our 6 week target. Additionally we maintained a downward trend in our average investigation time which was 54 weeks this year from 64 weeks in 2023-24.

Overview of health board complaints

During 2025-26, we received 1,351 complaints about health boards marking a significant 42% increase from the previous year. Clinical treatment in hospitals remains the most frequent source of concern. Additionally, complaint handling accounted for approximately 14% of complaints. While this represents a positive decline from 18% 2 years ago, specific concerns in this area are detailed below.

We intervened in 22% of health board complaints that we closed – compared to 27% last year.

Performance specific to your organisation

During 2025-26, we received 173 complaints about your organisation and closed 172 complaints (some of which may have been carried over from the previous year).

We intervened in 19% of the complaints we closed about your organisation.

We published 1 public report in the public interest relating to your Health Board. As you will be aware, this case concerned the removal of a patient from an orthopaedic surgery waiting list and there was a failure to rectify the position for more than a year despite the existence of complaints **(202400797)**.

Recommendations made and accepted by the Health Board included an apology, redress, audit of surgery waiting lists and governance oversight of it. I am pleased to note that whilst there was some delay in providing my office with satisfactory evidence a final recommendation has since been implemented satisfactorily.

Overall, we made 94 new recommendations to your organisation in the cases closed this year.

There were 93 recommendations that fell due during this period. Your organisation complied with 72% of these within the agreed timescales.

Detailed data on the complaints we handled about your organisation in this period can be found in the appendices below.

Improving compliance with our recommendations

We always take time to ensure that recommendations and timescales are agreed with public bodies before finalising them. Therefore we expect agreed deadlines to be met. Timely compliance is not, however, as high as it should be; with only 69% of our recommendations across Wales complied with on time as at 31 March 2026. Promptly delivering agreements to resolve injustice or hardship for individuals, and implementing systemic learning on time, is vital to build and maintain public trust in both our office and your organisation.

We recognise that unexpected challenges arise that make deadlines difficult to meet. In response to feedback from public bodies, we have adapted our approach moving forward: if you request a reasonable extension on or before the original deadline, and you meet that new date, it will be recorded as complied with on time. We hope this is a welcome adjustment that will help demonstrate a more accurate compliance rate over the coming years.

Supporting improvement of public services – key themes and our own initiative work

When an investigation reveals serious systemic risks that may affect many individuals, or offer wider sector lessons, we publish a public interest report. We published 9 such reports during this period, the vast majority concerning health boards. If you have not already done so, I encourage you to read these reports for their valuable insights - here.

Tragically, we have seen some instances of both individual shortcomings and wider systemic failures causing injustice to citizens in Wales. Key themes in this period have included: poor waiting list management (including inappropriate removal of patients from waiting lists); poor prescribing practice failures where we have seen communication and process breakdown between medical and pharmacy teams; and delays and clinical failures in urgent cancer referrals and ophthalmology.

We have also seen concerning complaint handling failures. Some health board complaint investigations have shown a lack of curiosity, objectivity and rigour which are essential to robust and thorough complaint investigation. In addition, we have seen failures to remain open and transparent with service users who have experienced harm, falling short of duty of candour requirements.

I strongly encourage all health boards and trusts to read the 5 public interest reports and recommendations issued during this period, and to use these insights to proactively strengthen your own complaint handling practices where appropriate.

We continue to expand the use of our own initiative powers. These allow us to investigate emerging issues proactively, addressing administrative failings before they multiply.

This year we issued a follow up report on public bodies' compliance with our previously published report on carers. You will recall I shared my original report with you given your role in identifying, assessing and supporting carers, especially during hospital discharge, and working collaboratively with others as part of an integrated system. Our follow up report can be found here.

Ongoing own initiative investigations

As at March 2026, we were conducting a further 4 own initiative investigations which focus, among other things, on:

- potential maladministration and service failure in health care
- how social landlords deal with complaints about disrepair and damp and mould.

We expect to complete this work later in 2026, and will determine then if the findings warrant publication in the public interest.

Our Complaints Standards Work

By the end of March 2026, all local authorities, health boards and 21 housing associations in Wales were operating under our model complaints policy. During 2025-26, we initiated the transition for the remaining housing associations and we expect them to be fully compliant by the end of September 2026.

Organisations that are already compliant, or will be shortly, account for 85% of new complaints about public services which we receive.

Our free complaint handling training remains highly requested; we delivered 58 sessions to public bodies across Wales this year, bringing our total since 2020 to over 600 sessions and 10,000 participants.

More broadly we expect to publish the data on complaints handled by local authorities in Wales during 2024-25 and 2025-26 in the Autumn.

Action we would like your organisation to take

To build on findings from this period, can I ask that your organisation takes the following actions:

- Present this Annual Letter and associated data to the Board at the next available opportunity and notify me of the planned meeting dates.
- Review the data in this letter, alongside your own data to better understand your performance, identify trends, and review your compliance with recommendations made by my office.

- Read the reports highlighted in this letter to extract relevant learning for your own Authority.

- Provide my office with a copy of your Annual Report for 2025-26 on the Duty of Candour and Quality.

- Inform me of the outcome of your considerations and proposed action plan at the earliest opportunity.

I would like to thank you, and your officers, for your continued openness and engagement with my office.

Yours sincerely

Michelle Morris
Public Services Ombudsman

Cc. paul.mears@wales.nhs.uk
ctm_psow@wales.nhs.uk

Information Sheet

Glossary of terms a guide to some of the terms used within our Annual Letters and Appendices.

Appendix A shows the number of complaints we received for all health boards in 2025-26. These complaints are contextualised by the population of each authority.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows intervention rates for all health boards in 2025-26. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix D shows outcomes of the complaints we closed for the Health Board in 2025-26. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix E shows the compliance performance of each health board.

Annual Letters - Glossary of terms

Term	Definition
Complaints received	The number of duly made complaints we receive about a Public Body.
Duly made complaint	A complaint about public services is duly made when: • the organisation is within our jurisdiction and • the organisation has replied or had the opportunity to reply and • the events complained about happened less than a year ago, or the complainant became aware of them less than a year ago (unless there was a good reason the complainant could not complain sooner) and • the complainant is entitled to bring a complaint and • we have the details we need e.g. name, contact details, organisation being complained about, we can understand the complaint. A complaint about a local councillor is duly made when: • we have the details we need e.g. name and contact details of the complainant, the name of the councillor and the Local Authority they are a member of • we have a signed declaration from the complainant and any third parties whose evidence has been submitted.
Early Resolution	A matter which is closed without investigation because there is an obvious solution and the body agrees to carry out action to resolve the matter. The body must give us evidence that it has taken action within the timeframe agreed.
Intervention	Cases which we have closed and we have either: • Upheld the complaint after investigation. • Resolved the complaint by way of Voluntary Settlement. • Resolved the complaint by way of Early resolution.

Voluntary Settlement	A matter which has progressed to investigation stage but closed without the investigation being completed because we agree that action which the body has voluntarily suggested it will take is appropriate to resolve the matter. The body must give us evidence that it has taken action within the timeframe agreed.
Uphold	A matter we have closed after investigation and where we found that something went wrong.
% of interventions	The number of public service complaints we closed that involved Early Resolution/Voluntary Settlement and those which we upheld following an investigation, divided by the total number of duly made public service complaints we closed in the reporting period.
Upheld %	The proportion of the complaints in which we intervened that we upheld in the reporting period, shown as a percentage.
Cases Closed	The number of complaints we closed during the reporting period. This may be different from the number we received because there may be some complaints we received in the previous reporting period but which we closed in this reporting period.
Recommendation	These are actions which we ask bodies to take within agreed timescales when we find something has gone wrong. These may be actions to help the individual complainant or systemic actions to help improve services for all service users. We can make recommendations as part of an Early Resolution, Voluntary Settlement or when upholding a complaint following investigation. When we make recommendations, organisations must provide evidence to us that they have complied.
Recommendations made	The number of recommendations we made to bodies during the reporting period. (1 April 2025 to 31 March 2026)
Recommendations falling due	The number of recommendations which needed to be complied with within the reporting period (1 April 2025 to 31 March 2026). Some recommendations will have been made in the previous reporting period but fell due within this reporting period.

Recommendations complied with in line with agreed target date %	The number of recommendations which were complied with by the agreed timescale as set out in Early Resolution, Voluntary Settlement or Investigation report (applicable for those falling due in 2025-26).
Population	Population is included to provide context, based upon the size of an organisation. However, it is recognised that complaints can be made by people who are not included in the population figure, for example, residents from outside the health board or local authority area, or non-contract holders. • For **local authorities**, population refers to the estimated total number of people living in the local authority area. The figures are taken from the StatsWales.[1] • For **housing associations**, population refers to the total stock at social rent, shown in units. This includes general needs stock, sheltered stock, other supported stock and extra care stock with non self-contained bedsits, hostels and shared housing. This figure is taken from StatsWales.[2] • For **health boards**, population refers to the estimated total number of people living in the health board area. The figures are taken from StatsWales.[3]

[1] Population estimates by local authority, year, sex and age | StatsWales
[2] Social landlord housing stock, including social and non social housing | StatsWales
[3] Population estimates by local health boards, year, sex and age | StatsWales

Appendix A – Complaints received (overview)

Health Board	Complaints Received	Population	Received per 1,000 residents
Aneurin Bevan University Health Board	263	601,686	0.44
Betsi Cadwaladr University Health Board	283	697,115	0.41
Cardiff and Vale University Health Board	230	519,662	0.44
Cwm Taf Morgannwg University Health Board	173	449,346	0.39
Hywel Dda University Health Board	172	389,160	0.44
Powys Teaching Health Board	31	135,059	0.23
Swansea Bay University Health Board	199	394,553	0.50
Welsh Ambulance Services University NHS Trust	37	-	-
Total	**1388**	**3,186,581**	**0.44**

Appendix B – Complaints received (by organisation)

Cwm Taf Morgannwg University Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	3	2%
Adult Mental Health	12	7%
Ambulance Services	1	1%
Appointment procedures (including outpatients)	5	3%
Care Homes	0	
Child and Adolescent Mental Health	0	
Clinical treatment in hospital	87	50%
Clinical treatment outside hospital; Dentist	0	
Clinical treatment outside hospital; GP	1	1%
Clinical treatment outside hospital; Other	4	2%
Clinical treatment outside hospital; Physiotherapist	0	
Complaints Handling	0	
Confidentiality	0	
Continuing care	2	1%
De-Registration	0	
Disclosure of personal information / data loss	1	1%
Finance and Taxation	0	
Funding	1	1%
Gender Identity Funding	0	
Health	32	18%
Housing	0	
Independent Health Care providers	0	
Medical records/standards of record-keeping	3	2%
Medication; Prescription dispensing	1	1%
Non-medical services	0	
Nosocomial (Framework)	0	
Other	1	1%
Other miscellaneous	0	
Out of Hours GP care	0	
Patient list issues	4	2%
Poor/No communication or failure to provide information	2	1%
Prisoner Care	1	1%
Recruitment and appointment procedures	0	
Referral to treatment time	5	3%
Rudeness/inconsiderate behaviour/staff attitude	7	4%
Services for vulnerable adults (eg with learning difficulties. or with mental health issues)	0	
Various Other	0	
Whistle-blowing	0	
Total	**173**	

Appendix C – Cases with PSOW intervention (overview)

Health Board	No. of interventions	No. of closures	% of interventions
Aneurin Bevan University Health Board	64	254	25%
Betsi Cadwaladr University Health Board	57	272	21%
Cardiff and Vale University Health Board	38	216	18%
Cwm Taf Morgannwg University Health Board	32	172	19%
Hywel Dda University Health Board	43	160	27%
Powys Teaching Health Board	7	28	25%
Swansea Bay University Health Board	49	195	25%
Welsh Ambulance Services University NHS Trust	8	36	22%
Total	**298**	**1333**	**22%**

Appendix D – Complaint outcomes (by organisation)

Cwm Taf Morgannwg University Health Board		% Share
Complaint investigation discontinued (with early resolution at assessment stages)	0	
Complaint investigation discontinued (without settlement)	1	1%
Decision not to investigate complaint	62	36%
Early resolution	27	16%
Matter out of jurisdiction	27	16%
Non-public interest report issued: complaint not upheld	9	5%
Non-public interest report issued: complaint not upheld with early resolution at assessment stage	0	
Non-public interest report issued: complaint upheld	4	2%
Non-public interest report issued: complaint upheld with early resolution at assessment stage	0	
Premature	41	24%
Public interest report issued: complaint upheld	1	1%
Public Interest report issued: complaint upheld with early resolution at assessment stage	0	
Special Interest Report	0	
Voluntary settlement	0	
Total	**172**	

Appendix E – Compliance performance comparison

Health Board	Number of recommendations made on complaints closed in 2025-26	Number of recommendations falling due in 2025-26	% of recommendations, complied with in line with agreed target date
Aneurin Bevan University Health Board	175	142	70%
Betsi Cadwaladr University Health Board	157	137	61%
Cardiff and Vale University Health Board	86	92	71%
Cwm Taf Morgannwg University Health Board	94	93	72%
Hywel Dda University Health Board	118	118	81%
Powys Teaching Health Board	9	10	70%
Swansea Bay University Health Board	143	144	60%
Welsh Ambulance Services University NHS Trust	23	36	83%