

Our ref: NB/LG/MM



[lucy.geen@ombudsman-wales.org.uk](mailto:lucy.geen@ombudsman-wales.org.uk)

[matthew.aplin@ombudsman-wales.org.uk](mailto:matthew.aplin@ombudsman-wales.org.uk)

Date: 28 July 2016

Sent by email

Dear Ms Paget

### **Annual Letter 2015/16**

Following the recent publication of my Annual Report I am pleased to provide you with the Annual Letter (2015/16) for **Aneurin Bevan University Health Board**.

Overall my office's caseload has increased by 4% this year, but I am pleased to say that public body complaints fell by the same amount; only the second time in a decade this has happened. However, disappointingly the NHS in Wales was the only sector in my jurisdiction that saw a rise in complaints which now count for over a third of all public body complaints; a total increase of 51% in the last five years.

As expected most complaints about the health sector related to clinical treatment in hospital but I'm pleased to see a drop in the number about clinical treatment outside hospital. Complaint handling is one area that saw a significant increase this year – over 60%. This suggests that health boards need to do more to ensure they are adhering to Putting Things Right and correctly implementing their local complaint handling processes.

This year saw an encouraging 20% increase in the number of public body complaints settled voluntarily. Once again there has been a slight drop in the number of complaints upheld by my office and just under half the number of Public Interest Reports issued. Of the seven Public Interest reports issued, five related to health boards. These reports covered a range of themes including poor management of sepsis, incorrect discharge and failure to correctly treat stroke.

Whilst an ageing population and continued austerity is placing greater strain on our health service, we must endeavour to drive up standards to improve patient experience in Wales. One way to do this is by giving patients a voice through learning from complaints. One way I intend to do this is by issuing special reports highlighting particular themes that arise from my investigations. I published the first of these in February focusing on the poor quality of out of hours care in Welsh hospitals, which called for an independent systemic review. If the new Ombudsman legislation comes in to effect this year, I plan to use own initiative powers to drive more of these thematic reports.

Last year I assigned Improvement Officers to five of Wales' Health Boards, along with an overall lead for Health, placing greater emphasis on best practice and corporate cultural development. I hope that through better engagement with these bodies there will be an improvement in complaint handling and learning from complaints; however I believe fresh legislation is required to really have an impact on ending poor service delivery. Now the Fifth Assembly is in place we will be pushing ahead with the new powers and I hope to see the new PSOW Act introduced early next year.

You will find below a factsheet giving a breakdown of complaints data relating to your health board along with explanatory notes.

This correspondence is copied to the Chair of your Health Board for consideration by the board. I will also be sending a copy to your contact officer within your organisation and would again reiterate the importance of this role. Finally, a copy of all annual letters will be published on my website.

**Yours sincerely**

A handwritten signature in black ink, appearing to read 'Nick Bennett', with a stylized flourish at the end.

Nick Bennett

Ombudsman

## **Factsheet**

There was a slight drop in complaints about your Health Board this year (from 102 to 93) but the number taken forward to investigation was only one less than 2014/15. The highest number of complaints was concerned with clinical treatment in hospital, followed by clinical treatment outside hospital and complaint handling. There was a small decrease in the number of cases upheld and I am pleased to see there were no Public Interest Reports issued this year.

### **Improvement Officer Review**

Early resolution of complaints is beneficial for both complainant and the Health Board. The Health Board has embraced this and worked hard on settling complaints that have come to my office, where it has been appropriate to do so. This positive approach is reflected in the complaint figures for outcomes to complaints to my office over the last year. There was a considerable increase in complaints which were settled at an early stage in the last half of the year. I welcome this and trust that this progress will continue. A further step would be to focus on resolution within the Health Board's own complaint process, before the complaint reaches my office. Earlier resolution and consistency of investigation of complaints remain areas for further work.

Implementing improvements as a result of complaints is an essential part of being an open and learning organisation and requires the ongoing commitment of staff at all levels of the Health Board. It can be hard in practice to achieve but the Health Board is aware of this challenge. Communication with medical and nursing staff (both with patients, their families and between different members of staff and departments), and inadequate clinical recording keeping, are recurring themes in a large number of complaints that come to my office. Aneurin Bevan Health Board is no exception. My Improvement Officer has found a positive response from Health Board staff and is keen to provide support to the Health Board in the year ahead to build on the improvements already made.

**A) Comparison of complaints received by my office with average for health bodies, adjusted for population distribution**

In total my office received **93** complaints during 2015/16 against Aneurin Bevan University Health Board compared to a health board average of **120**.

**B) Comparison of complaints by subject category with Health Board average**

<b>Subject</b>	<b>2015/16 Aneurin Bevan University Health Board</b>	<b>2015/16 Health Board Average</b>
Appointments/ Admissions/ Discharge and transfer procedures	5	5
Clinical treatment in hospital	62	51
Clinical treatment outside hospital	7	6
Continuing care	5	8
Medical records/ Standards of record keeping	0	1
Non-medical services	0	1
Services for older people	1	0
Services for vulnerable adults	0	1
Patient list issues	0	2
Complaint-handling	6	10
De-registration	0	0
Rudeness/inconsiderate behaviour/staff attitude	0	0
Poor/no communication or failure to provide information	1	1
Regulation and Inspection	0	0
Recruitment and appointment procedures	0	0
Other	6	7
<b>TOTAL</b>	<b>93</b>	<b>93</b>

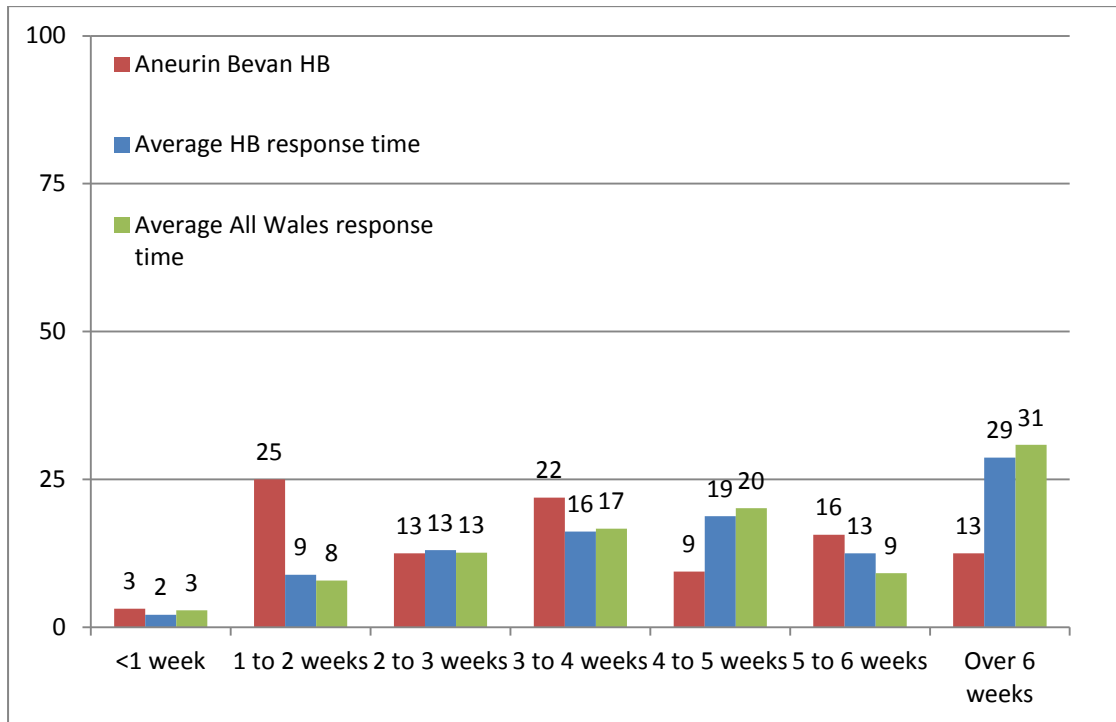
**C) Complaints taken into investigation by my office with health board average**

	<b>2015/16 Aneurin Bevan University Health Board</b>	<b>2015/16 Health Board Average</b>
Number of complaints taken into investigation	32	36

**D) Comparison of complaint outcomes with Health Board average, adjusted for population distribution**

<b>Complaint Outcomes</b>	<b>2015/16 Aneurin Bevan University Health Board</b>	<b>2015/16 Health Board average</b>
Out of jurisdiction	9	11
Premature	15	23
'Other' cases closed after initial consideration	28	33
Discontinued	0	1
Quick fix / Voluntary settlement	12	21
Section 16 – Upheld – in whole or in part	0	1
Other report upheld – in whole or in part	21	19
Other report – not upheld	9	10
Withdrawn	3	3

**E) Comparison of Health Board times for responding to requests for information with average for health bodies and All Wales response times, 2015/16 (%)**



**F) Summaries**

[Casebook 21](#)

201400365

201404008

201402128

201401016

201402291

201306023

201303601 & 201303581

201403343

201404113

201404927

201404937

201403390

201408829

[Casebook 22](#)

201401141

201403090

201404810

201402637

201405743

201402689

201403475

201408747

201501031

201501486

201501652

201403526

201500895

[Casebook 23](#)

201404515

201405048

201404388

201405977

201501342

201502093

[Casebook 24](#)

201405404

201500179

201501426

201501062

201501821

201503199

201504019-

201501401

201506210



## **Appendix**

### **Explanatory Notes**

Section A compares the number of complaints against the Health Board which were received by my office during 2015/16, with the Health Board average (adjusted for population distribution) during the same period.

Section B provides a breakdown of the number of complaints about the Health Board which were received by my office during 2015/16 with the Health Board average for the same period. The figures are broken down into subject categories.

Section C provides the number of complaints against the Health Board which were investigated by my office during 2015/16 with the Health Board average (adjusted for population distribution) during the same period.

Section D compares the complaint outcomes for the Health Board during 2015/16, with the average outcome (adjusted for population distribution) during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section E compares the Health Board's response times during 2015/16 with the average response times for all Health Boards and all public bodies in Wales during the same period. This graph measures the time between the date my office issued an 'investigation commencement' letter, and the date my office receives a full response to that letter from the public body.

Finally, Section F contains the summaries relating to the Health Board appearing in the Ombudsman's Casebook during 2015/16.

### **Feedback**

We welcome your feedback on the enclosed information, including suggestions for any information to be enclosed in future annual summaries. Any feedback or queries should be sent to [lucy.geen@ombudsman-wales.org.uk](mailto:lucy.geen@ombudsman-wales.org.uk) or [matthew.aplin@ombudsman-wales.org.uk](mailto:matthew.aplin@ombudsman-wales.org.uk)