

Our ref: NB/LG/MM



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Sent by email

Dear Mr Doherty

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 **Betsi Cadwaladr 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 has been a marked increase in the number of complaints about your Health Board received by my office this year (32%) which is reflected by the higher number taken forward to investigation (67%), taking both well above the health board average. Once again clinical treatment in hospital received the most complaints, and also saw the largest increase but it is encouraging to see that the number of complaints about clinical treatment outside hospital nearly halved. However it is very concerning that the number of complaints about your Health Board's complaint handling processes has increased from 5 to 19 – an increase of 280%. This is an area that needs to be addressed in the coming year. There was a slight drop in the number of upheld complaints but this year again I had to issue a Public Interest Report, this time about poor clinical treatment and discharge procedures.

Improvement Officer Review

The support offered by my Improvement Officer was welcomed and I am pleased to say that, over the last 12 months, we have developed a regular and open channel of communication. This allows us to closely monitor complaints to my office and compliance with recommendations, have frank discussions about fundamental issues affecting the Health Board, identify risks and formulate action plans.

We have also shared information on good practice in complaint handling. This has resulted in an improvement in response times to observation requests, an increased number of voluntary settlements and a reduction in the number of complaints I have taken forward for investigation, as well as those that are subsequently upheld. I am pleased to say that, in some cases, the Health Board figures are significantly better than the "Health Board Average".

Despite the significant challenges the Health Board has experienced over the last year, it is clear that complaint handling and learning from complaints remains a priority. The Health Board is currently changing its process to make it clearer and more efficient and, whilst there has been an increase in the number of complaints received this year (38 additional complaints), I am confident that, once the changes start to bed in, there will be a positive effect on the number of complaints received by my office. That said, there is still work to be done so, looking to the future, it is my intention that my Improvement Officer continues to work positively with the Health Board. Together we can identify and target other areas of concern and create a new action plan for the year ahead, while maintaining all of the achievements from the past 12 months.

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

In total my office received **156** complaints during 2015/16 against Betsi Cadwaladr University Health Board compared to a health board average of **144**.

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

Subject	Betsi Cadwaladr Health Board 2015/16	Health Board Average 2015/16
Appointments/ Admissions/ Discharge and transfer procedures	1	5
Clinical treatment in hospital	92	51
Clinical treatment outside hospital	9	6
Continuing care	6	8
Medical records/ Standards of record keeping	3	1
Non-medical services	1	1
Services for older people	0	0
Services for vulnerable adults	1	1
Patient list issues	4	2
Complaint-handling	19	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	1	0
Recruitment and appointment procedures	0	0
Other	18	7
TOTAL	156	93

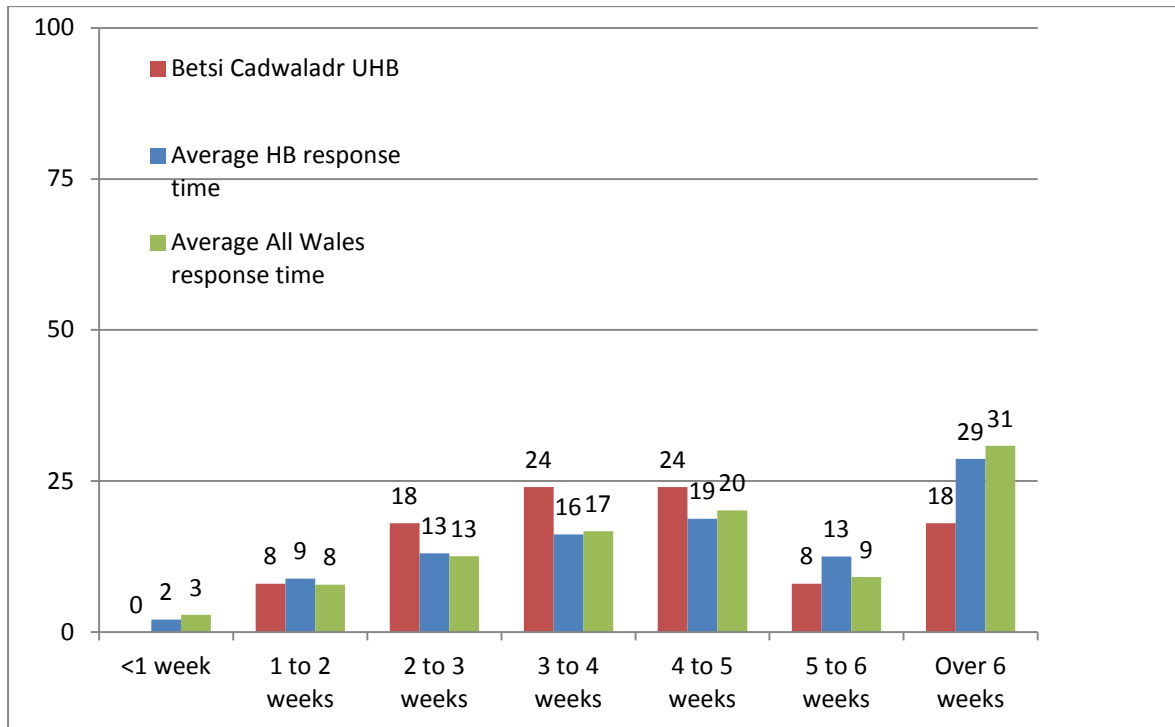
C) Complaints taken into investigation by my office with health board average

	2015/16 Betsi Cadwaladr	2015/16 HB average
Number of complaints taken into investigation	50	43

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

Complaint Outcomes	2015/16 Betsi Cadwaladr	2015/16 Health Board Average
Out of jurisdiction	11	13
Premature	27	27
'Other' cases closed after initial consideration	40	40
Discontinued	0	1
Quick fix / Voluntary settlement	24	25
Section 16 – Upheld – in whole or in part	1	1
Other report upheld – in whole or in part	21	22
Other report – not upheld	8	12
Withdrawn	3	4

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](#)

201306094

201401050

201401636

201306936

201400302

201404991

201409643

201409136

201409329

[Casebook 22 July](#)

201405067

201400725

201404465

201402308

201402729

201405627

201404246

201403077

201501537

201502859

201502396

201502694

201502076

201205177

[Casebook 23](#)

201404628

201405883

201408391

201502101

201404585

201406084

201403937

201503451

201504721

201503027

201503952

201502561

201504277

[Casebook 24 January – March 2016](#)

201501221

201501946

201500485

201500659

201409310

201501341

201501717

201502545

201409629

201501122

201501779

201505450

201505058

201504820

201503785

201504667

201505025

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 or matthew.aplin@ombudsman-wales.org.uk