

Our ref: NB/LG/MM



lucy.geen@ombudsman-wales.org.uk

matthew.aplin@ombudsman-wales.org.uk

28 July 2016

Sent by email

Dear Mr Moore

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 **Hywel Dda 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 large, sweeping flourish at the end.

Nick Bennett

Ombudsman

Factsheet

With regards to your Health Board, the number of complaints received by my office marginally decreased from 101 in 2014/15 to 98 in 2015/16. The vast majority of these cases were about clinical treatment in hospital (46) and complaint handling (25). There were 24 cases were taken into investigation compared to 15 last year.

Improvement Officer Review

My Improvement Officer has found the Health Board has been welcoming and open in sharing information and engaging from the outset. This is demonstrated most clearly by the 50% increase in early resolutions (“quick fixes”) achieved in the past year. A satisfactory and quick resolution is a more positive experience for not only the complainant but also everyone involved.

The Health Board has clearly worked hard in the past year to clear a significant backlog of concerns that had built up and were still outstanding. However, some very serious delays were found in a few cases. This is naturally reflected below in the number of cases about complaint handling alone but it is also a feature in a number of those other cases which has clinical care as the main focus of the complaint.

It would be fair to say that in many of the cases evidencing serious delays a recurring identifiable issue has been the significant delay of clinicians in engaging in the complaints investigation. This was amply illustrated from files seen. There were repeated attempts from complaint handlers to get relevant comments or information from some clinicians, with the inevitable delay this caused in then responding to the complainant. Unsurprisingly, many of those complainants who become aware of the delay in clinician response will be dissatisfied with the actual response on receipt, perceiving, rightly or wrongly, that the reticence or delay on the part of the clinician must indicate there is “something to hide”.

My Improvement Officer’s goal this year is to improve greater clinician engagement in complaints early on in the process, so enabling the complaint handler to achieve better timeliness of complaint handling overall. Therefore, as a starting point, my officer will be involved in the Health Board’s Consultant Education Programme where she intends to convey this message, and the overall benefits in turn it brings for the Health Board and complainant overall.

Finally, the Health Board has evidently taken some positive steps to respond to findings made by my office over the past year in an effort to improve, including additional proposed structure changes. I hope that this culture of openness and learning continues.

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

In total my office received **98** complaints during 2015-16 against **Hywel Dda University Health Board** compared to a health board average of **80**.

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

Subject	Hywel Dda University Health Board 2015/16	Health Board Average 2015/16
Appointments/ Admissions/ Discharge and transfer procedures	8	5
Clinical treatment in hospital	46	51
Clinical treatment outside hospital	4	6
Continuing care	3	8
Medical records/ Standards of record keeping	2	1
Non-medical services	1	1
Services for older people	0	0
Services for vulnerable adults	0	1
Patient list issues	2	2
Complaint-handling	25	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	1	0
Other	5	7
TOTAL	98	93

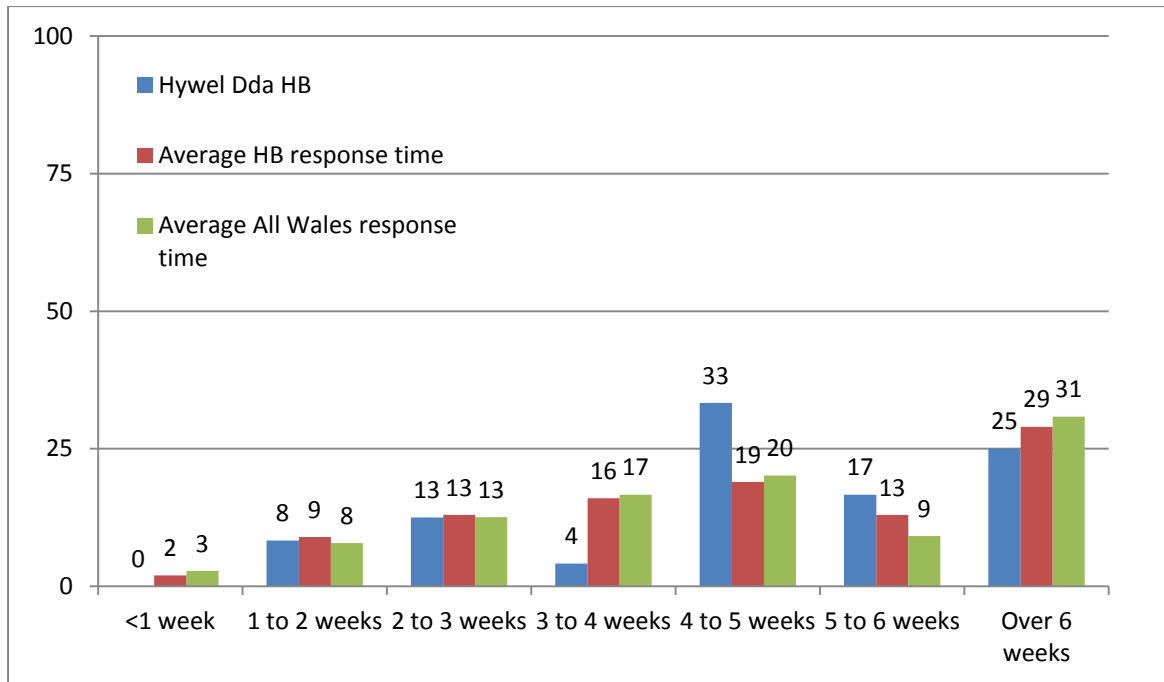
C) Complaints taken into investigation by my office with health board average

	2015/16 Hywel Dda University Health Board	2015/16 Health Board Average
Number of complaints taken into investigation	24	24

D) Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

Complaint Outcomes	2015/16 Hywel Dda University Health Board	2015/16 Health Board average
Out of jurisdiction	7	7
Premature	27	15
'Other' cases closed after initial consideration	18	22
Discontinued	1	0
Quick fix / Voluntary settlement	32	14
Section 16 – Upheld – in whole or in part	1	0
Other report upheld – in whole or in part	14	12
Other report – not upheld	1	6
Withdrawn	1	2

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

201400661

201402730

201401438

201400501

201408101

201402765

201500810

201409197

201408090

Casebook 22

201404798

201502226

201408672

201409337

201502689

201501351

201501305

201502108

201404798

201502226

201408672

201409337

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Casebook 23

201503905

201408108

201500389

201404436

201408459

201500885

201500635

201504216

201503940

201408844

201501440

201502635

201501305

201409309

Casebook 24

201408260

201501606

201502260

201504804

201504473

201505331

201505686

201505748

201505930

201501208

201505031

201504754

201504477

201504886

201503956

201505019

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 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