Our ref: PT/jm
Ask for: James Merrifield

Your ref:
01656 644 200

Date: 9 July 2013
James.Merrifield@ombudsman-wales.org.uk

Professor Trevor Purt
Chief Executive
Hywel Dda Local Health Board
Merlin's Court
Winch Lane
Haverfordwest
Pembrokeshire
SA61 1SB

Dear Trevor

**Annual Letter 2012-2013**

Following the recent publication of my Annual Report, I am pleased to provide you with the Annual Letter (2012-2013) for Hywel Dda Health Board.

As outlined in my Annual Report, the number of new complaints to my office increased by 12% compared with 2011/12. Health complaints continue to be the most numerous type of complaint and now account for more than a third of all complaints received. Whilst some of the increase can be attributed to changes brought about under the Putting Things Right redress arrangements, the increase almost certainly reflects a greater dissatisfaction with the health service.

In reference to the overall performance of Health Boards in Wales, there has been a 35% increase in the number of investigation reports issued by my office during 2012/13 compared with 2011/12. I have also again had cause to issue a number of Public Interest Reports identifying serious concerns and failings, all of which have concerned health bodies. Whilst the average number of 'not upheld' reports issued against health bodies has remained the same as last year, I am disappointed to note such a large increase in the average number of 'upheld' reports from 11 to 21 reports.

It is worth noting a further year-on-year increase in the levels of 'Quick Fixes' and 'Voluntary Settlements' achieved by this office, from 13 to 16 cases. In order to maximise the opportunities to learn lessons from these types of cases, you can now

find the summaries of quick fixes and voluntary settlements included in my quarterly publication, The Ombudsman's Casebook.

However, I am disappointed to note that the amount of time taken by public bodies in Wales in responding to requests for information from my office has not improved. I am concerned that 45% of all responses took longer than five weeks, with 28% of responses taking in excess of 6 weeks. Whilst I appreciate that resources are stretched at this time, such delays obstruct me from providing complainants with the level of service which they should rightly expect to receive and I urge all Welsh public bodies to review their performance.

In reference to your Health Board, there has been an increase in the number of complaints received by my office, compared with 2011/12. Whilst there has also been an increase in the number of complaints taken into investigation, this figure remains at the same level as the health body average. There has been a noticeable increase in the number of quick fixes and voluntary settlements compared with 2011/12. Whilst the number of 'upheld' reports issued by my office is below the health body average, it has also been necessary for my office to issue two Public Interest Reports in relation to your Health Board. It is disappointing to note that almost three-quarters of responses to requests for information from my office were received more than five weeks after they were requested.

As with previous exercises, I have copied this correspondence to the Chair of your Health Board with the intention that it be considered by the Board. I would also welcome the opportunity to meet and my office will be in contact shortly to make the necessary arrangements. Finally, a copy of this letter will be published on my website.

Yours sincerely

Peter Tyndall
Ombudsman

Copy: Chair, Hywel Dda Health Board

# Appendix

**Explanatory Notes**

Section A compares the number of complaints against the Health Board which were received by my office in 2012-2013 with the average for health bodies (adjusted for population distribution[1]) during the same period.

Section B provides a breakdown of the number of complaints received by my office, broken down into subject categories.

Section C compares the number of complaints against the Health Board received by my office during 2012-2013, with the average for health bodies during this period. The figures are broken down into subject categories.

Section D provides the number of complaints against the Health Board which were taken into investigation by my office in 2012-2013.

Section E compares the number of complaints against the Health Board which were taken into investigation by my office in 2012-2013, with the average for health bodies (adjusted for population distribution) during the same period.

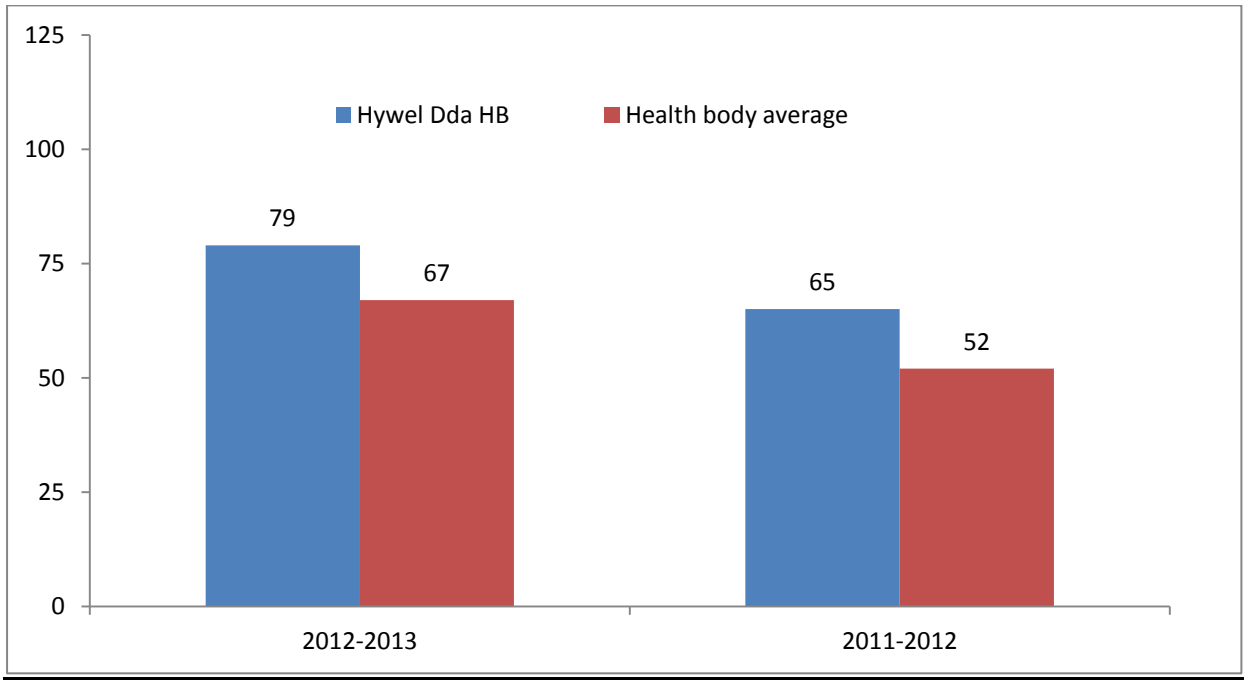
Section F compares the complaint outcomes for the Health Board during 2012-2013, with the average outcome for health bodies during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section G compares the Health Board's response times during 2012-2013, with the average response times for health bodies, and the average for 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 H contains the summaries of all reports issued in relation to the Health Board during 2012-2013.

[1] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039

## A: Comparison of complaints received by my office with average for health bodies

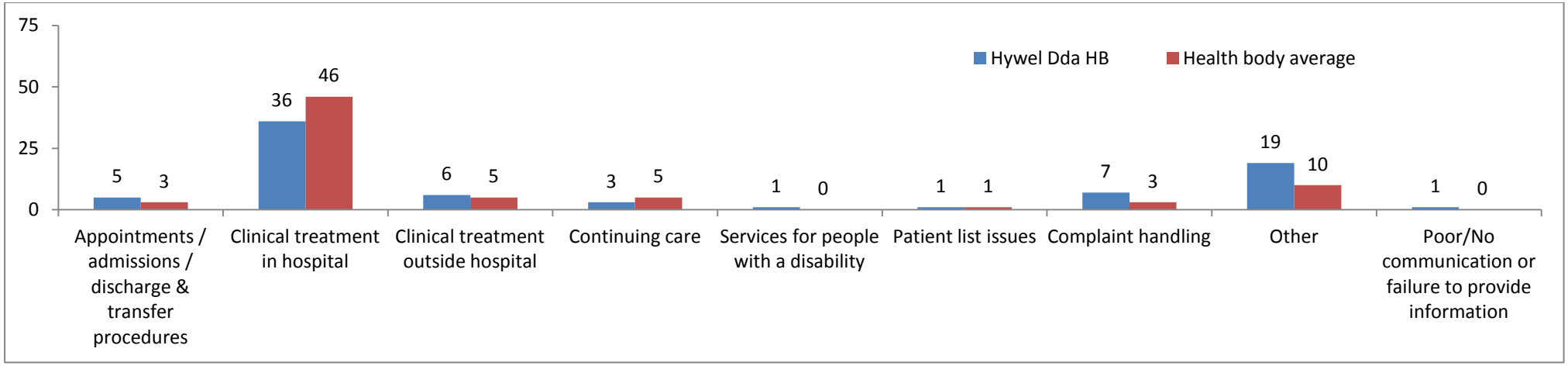



## B: Complaints received by my office

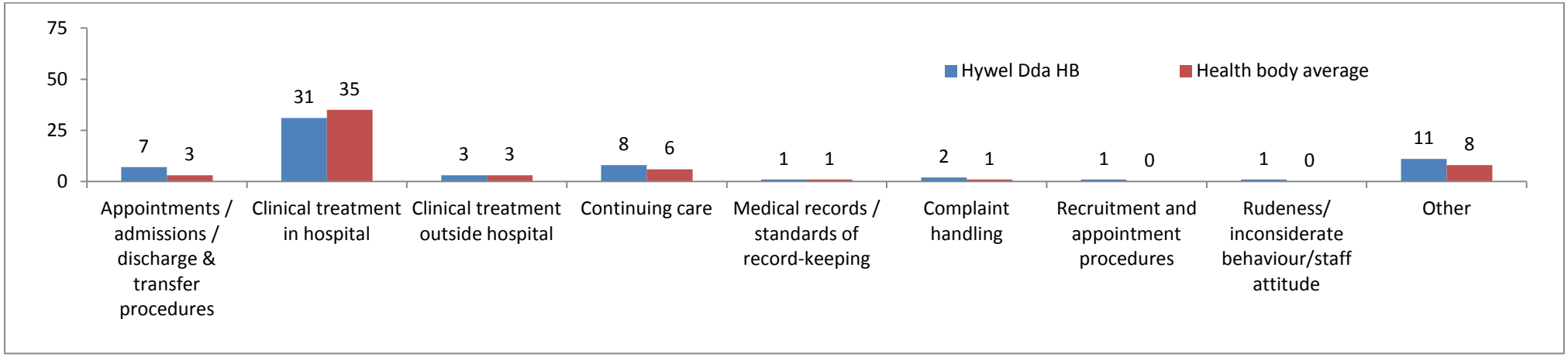
| Subject | 2012-2013 | 2011-2012 |
|---|---|---|
| Appointments/ Admissions/ Discharge and transfer procedures | 5 | 7 |
| Clinical treatment in hospital | 36 | 31 |
| Clinical treatment outside hospital | 6 | 3 |
| Continuing care | 3 | 8 |
| Medical records/standards of record-keeping | 0 | 1 |
| Services for people with a disability | 1 | 0 |
| Patient list issues | 1 | 0 |
| Complaint-handling | 7 | 2 |
| Recruitment & appointment procedures | 0 | 1 |
| Rudeness/inconsiderate behaviour/staff attitude | 0 | 1 |
| Poor/no communication or failure to provide information | 1 | 0 |
| Other | 19 | 11 |
| **TOTAL** | **79** | **65** |

## C: Comparison of complaints by subject category with average for health bodies

### 2012-2013



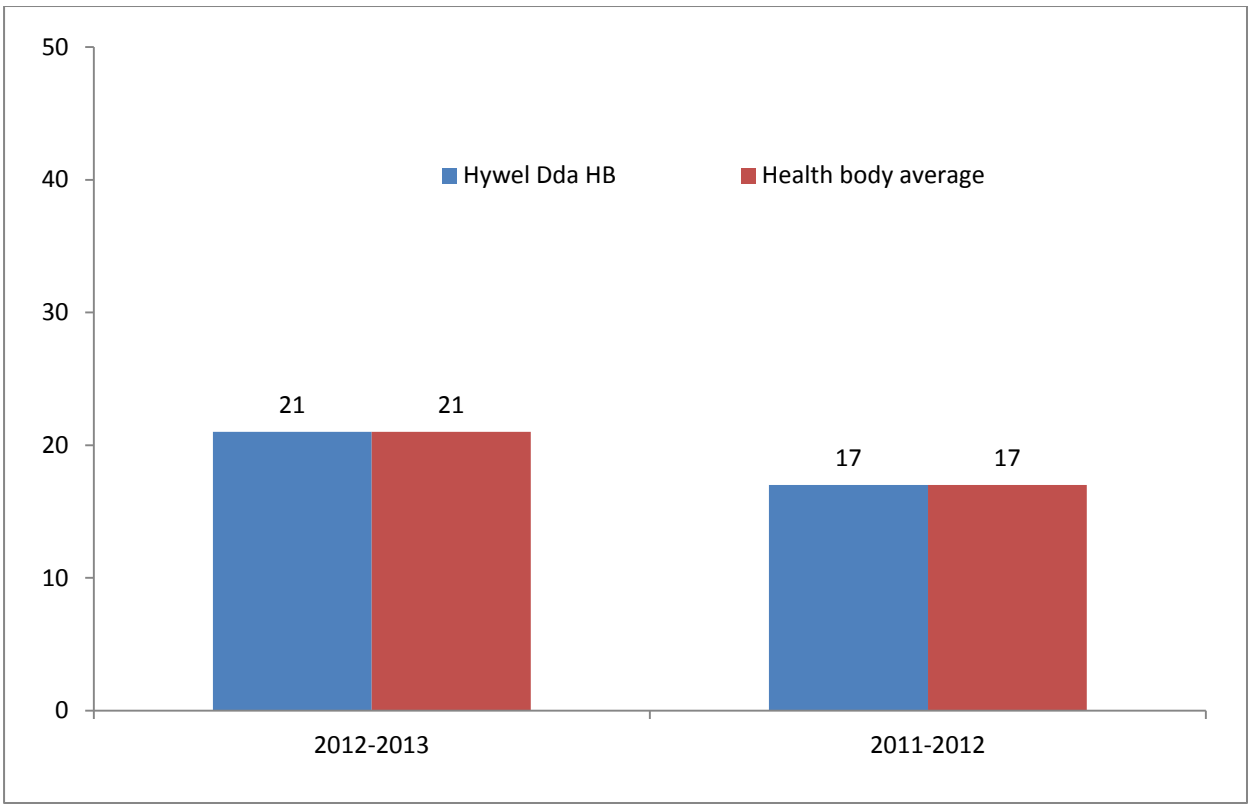

### 2011-2012



## D: Complaints taken into investigation by my office

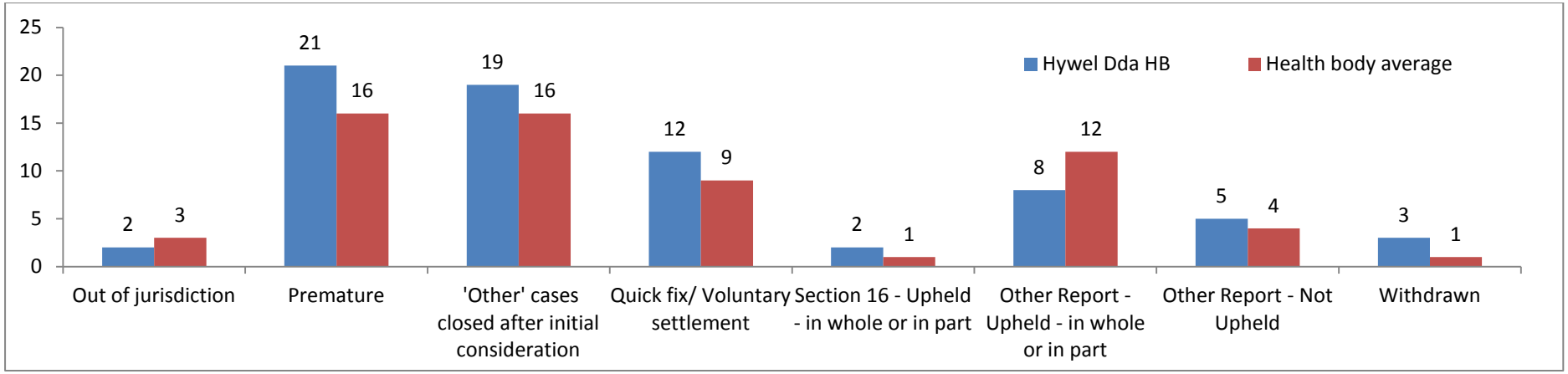
| | 2012-2013 | 2011-2012 |
|---|---|---|
| Number of complaints taken into investigation | 21 | 17 |

## E: Comparison of complaints taken into investigation by my office with average for health bodies

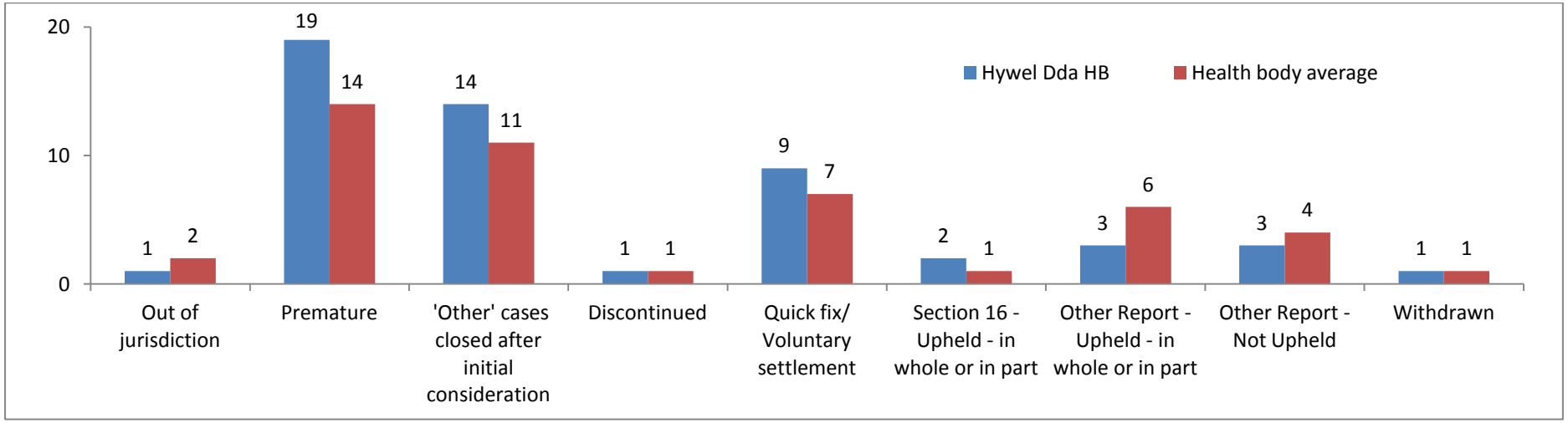


## F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

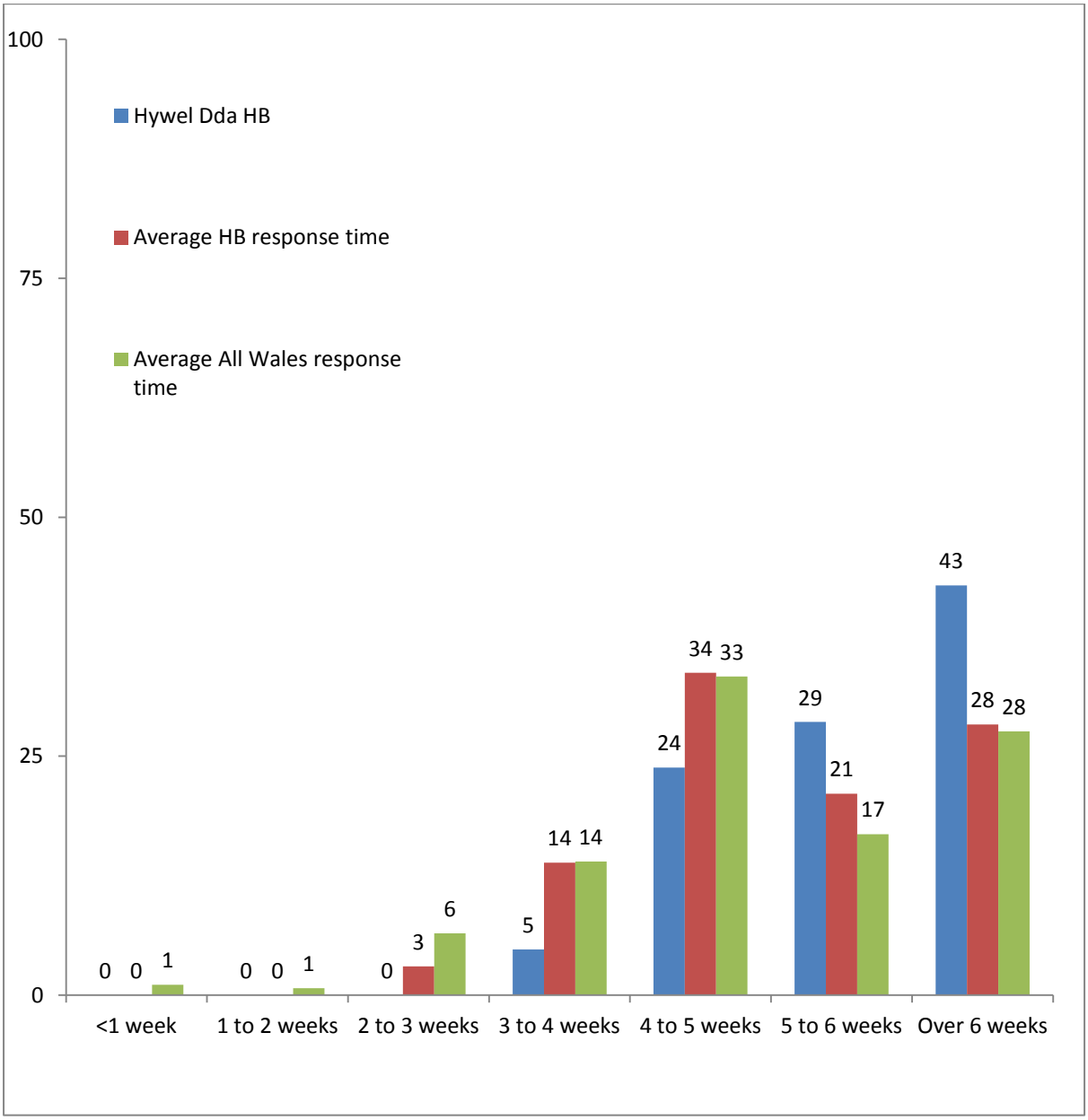
### 2012-2013




### 2011-2012



## G: Comparison of Health Board times for responding to requests for information with average for health bodies and All Wales response times, 2012-2013 (%)



## H: Report summaries

### Public Interest Reports

**September 2012 – Clinical treatment in hospital – Hywel Dda Health Board**
Mrs F complained about matters concerning her daughter's treatment at one of Hywel Dda Health Board's hospitals in 2011. She explained that her daughter, Miss F, had a severe form of endometriosis, which is a gynaecological condition. Mrs F said that the hospital mismanaged her medical care, failed to refer onward to a more specialist hospital in another area and mishandled her complaint.

The Ombudsman upheld her complaints. He noted that the hospital had operated on Miss F twice. The second operation was poorly planned and Miss F was badly prepared psychologically and physically. Moreover, she should have been referred to a more specialist unit after the first operation. In the event, Miss F's second operation was abandoned without success and clinicians decided to refer her to the other hospital. The Ombudsman concluded that the hospital played a part in the referral initially failing. In addition, he criticised the Health Board concerning the handling of Mrs F's complaint.

The Ombudsman recommended that the Health Board apologise to Miss F and pay her £3250 as an acknowledgement of the injustice she suffered due to the failings identified. This included an unnecessary operation. He made a number of further recommendations including work to ensure that patients are prepared properly for gynaecological operations, action to prevent a recurrence of the planning failures in Miss F's case and improving referral pathways. The Health Board accepted the Ombudsman's recommendations.
**Case reference 201202690**

**April 2012 – Clinical treatment in hospital – Hywel Dda Health Board**
Ms R complained about Hywel Dda Health Board ("the HB"). Her complaint related to treatment that her late father received at Bronglais Hospital ("the Hospital") in December 2008 and subsequent events. Ms R said that her father was admitted to Hospital after becoming unwell aged 80 years. Among other matters, Ms R complained that the Hospital failed to record important information about his diabetic regime and did not monitor his blood sugar properly. She added that there was evidence to suggest that nursing staff amended the records of her father's blood sugar monitoring to hide their failures. Ms R explained that sadly her father had a hypoglycaemic attack during the period of poor monitoring, which she believed contributed to a cardiac arrest. Her father died a few months later. Ms R added that the response to her complaint by the predecessor body to the HB and later the HB, was not robust.

The Ombudsman upheld Ms R's complaint. He concluded that the Hospital did not record and therefore act upon, important details about her father's diabetic regime and failed to monitor his blood sugar levels properly. The Ombudsman found that the hypoglycaemic attack, to which the Hospital's failings contributed, had an unspecific causal effect on the patient's subsequent cardiac arrest and deterioration. The Ombudsman also concluded that there appeared to be a deliberate attempt to cover

up the lack of blood sugar monitoring. He found the internal complaint investigations, that took place before his involvement, were inadequate.

The Ombudsman made a number of recommendations to the HB. These included paying Ms R and the family a total of £1700 as an acknowledgement of the uncertainty and distress over how the failings might have contributed to her father's demise and the extensive time that they had spent pursuing the complaint. He also recommended various systemic reviews, audits and training. The HB undertook to implement his recommendations.

**Case reference 201100456**

## Other Reports – Upheld

**March 2013 – Clinical treatment in hospital – Hywel Dda Health Board**
Mrs E complained about the treatment that her late mother, Mrs R received at the A&E department of Prince Phillip Hospital. Mrs R had been admitted at 5.40am and sadly passed away later that same day at 11.40pm. Mr E complained about the nursing care that her mother received, that her mother's raised temperature had been missed on admission and that she had not been given antibiotics in a timely fashion. Mrs E said that there had a failure to properly diagnose and provide treatment for her mother at an early stage.

The A&E Adviser said that Mrs R's symptoms were incorrectly attributed to being a consequence of a muscle strain which was considered poor and below a reasonable standard. The Respiratory Adviser said that Mrs R's diagnosis had been missed and there were clues which pointed towards an infection or an acute condition. This Adviser said there was a clear failure to diagnose pneumonia and commence antibiotic treatment. The Adviser said that had Mrs R been treated early, aggressively and appropriately for pneumonia it could have resulted in a better outcome for Mrs R. The Nursing Adviser said that following an elevated MEWS (Modified Early Warning System, which measures essential parameters for safe patient care) score further observations should have been conducted on Mrs R and that it was unacceptable that Mrs R was not then observed for another three hours and twenty minutes. The Nursing Adviser said that there was little evidence Mrs R received nursing care and there were no care plans in place.
The complaint was upheld and recommendations were made that:

• the Chief Executive should apologise to Mrs E;
• the Health Board pay £5,000 to recognise and acknowledge the distress to Mrs E due to failings identified;
• the Health Board undertake an investigation into misjudgements made by clinicians;
• the Health Board specify actions and remedial measures taken to avoid repetition
• the Health Board review care plans to ensure compliance with Fundamentals of Care;
• the Health Board undertake a review of the MEWS scoring system and an audit of the management of patients presenting with community acquired pneumonia against the British Thoracic Society guidelines.

The HB agreed to implement these recommendations.
**Case reference 201103945**

**March 2013 – Clinical treatment outside hospital – Abertawe Bro Morgannwg University Health Board & Hywel Dda Health Board**
Mr K complained to the Ombudsman about delays following the referral of his late wife for diagnosis and treatment from the maxillofacial department of Withybush Hospital to Morriston Hospital. Following surgery for a tumour in her mouth, Mrs K remained under the care of Morriston hospital. However, sadly the cancer returned and Mr K complained about delays by the hospital in identifying the recurrence of the cancer. The Ombudsman's investigation found that there had been an unreasonable delay in the initial referral of Mrs K to Morriston Hospital and that there was a further delay at Morriston before surgery was performed to remove the tumour. The

Ombudsman found however that whilst the delay would have been distressing for Mr and Mrs K, there was no evidence that the delay would have impacted on the success or otherwise of the surgery.

The Ombudsman was unable to conclude on the basis of the evidence available that the care provided at Morriston Hospital was unreasonable in terms of identifying the recurrence of Mrs K's cancer. Accordingly the Ombudsman upheld the first two aspects of Mr K's complaint but did not uphold the third. He recommended that the Health Boards apologise to Mr K and to implement changes to their procedures.
**Case reference 201201080 & 201201082**

**February 2013 – Clinical treatment in hospital – Hywel Dda Health Board**
Mr and Mrs J complained that Mrs T, the mother of Mrs J had not been cared for properly on two occasions when she was in hospital. Mrs T had firstly been admitted to the hospital in April 2009 when she had fractured her hip during a fall at her care home. She had undergone surgery on the next day, which appeared to have been successful, although she suffered a heart attack after the operation. The family became concerned when Mrs T appeared to be unwell and hallucinating. It emerged that she had been given the medication of another patient, who had left, in addition to her own. It took some time for the staff to give accurate information to the family on this matter. On a subsequent emergency admission in May 2009, Mrs T was given a drug for pain management that was unsuitable for her. She sadly died in June 2009 of a presumed cardiac arrest and there was no post mortem. The family was concerned at numerous aspects of her care and remained concerned that the drug misprescriptions had contributed to her death.

The Ombudman's clinical advisers said that the Board had failed to deal promptly with the first drug misprescription, which was a notifiable incident. They expressed concern at the failure of several members of staff to realise that they were giving Mrs T the wrong drugs. There had also been a lack of openness with the family about what had happened. There were deficiencies identified in record keeping and discharge documentation. The complaint was substantially upheld. The advisers could find no evidence however that the drug misprescriptions had contributed to Mrs T's death.

The report's recommendations, which were accepted by the Board, included improved guidance and training for staff and that the Board should satisfy itself as to the professional competence of those staff involved in the drug errors.
**Case reference 201103389**

**January 2013 – Clinical treatment in hospital – Hywel Dda Health Board**
Mrs B complained about treatment received by her late father, Mr K, at West Wales General Hospital in 2007. The Hospital is now managed by Hywel Dda Health Board. Mrs B made numerous criticisms of the care provided after Mr K had suffered an abdominal aortic aneurysm. He later died in the Hospital. She said that the Hospital mishandled Mr K's naso-gastric feeding, did not carry out suctioning regularly enough and did not institute a prudent tracheostomy regime. She raised further matters including poor staff attitudes.

The Ombudsman upheld her complaints to a significant extent, whilst not agreeing with all her points. In particular, he found that staff failed to properly check the position of the naso-gastric tube, did not provide suctioning regularly enough and did not respond effectively to evidence that Mr K might have been at risk of aspiration when feed appeared around the tracheostomy site. The Ombudsman identified that a degree of uncertainty remained about whether the latter issue might have influenced the sad outcome. He also considered that the former managing body did not fully investigate the accusations of poor staff attitudes.

The Ombudsman recommended that the Health Board pay Mrs B £750 as an acknowledgement of the uncertainty that remained about how the failings might have been a factor in Mr K's demise. He also recommended that the Health Board implement an action plan to address his concerns and/or reassures him that changes over the last five year have dealt with identified shortcomings. The Health Board agreed to carry out the Ombudsman's recommendations.

**Case reference 201203194**

**December 2012 – Clinical treatment in hospital – Hywel Dda Health Board**

Mr A complained about the Health Board's management of his ankle injury. He said that it failed to diagnose a fracture, to his right ankle, on two separate occasions. He also suggested that it should have investigated a bony growth on his shin bone because this could have been causing the pain that he was experiencing. He reported that one of the doctors, who treated him, made "unjustified" and "insulting" comments. He also complained about the Health Board's complaint handling. He suggested that it had not taken his complaint seriously because of the length of time that it took to provide him with a full response to it. He indicated that this response was "patronising". He also noted that the Health Board's apparent acceptance of missed fractures, when responding to his complaint, concerned him.

The Ombudsman did not uphold the ankle injury aspect of Mr A's complaint. He partly upheld the complaint handling element of it. He recommended that the Health Board should apologise to Mr A for failing to give him sufficient information about the progress of its investigation into his complaint. The Health Board agreed to comply with this recommendation.

**Case reference 201103659**

**July 2012 – Clinical treatment in hospital – Hywel Dda Health Board**

Ms P complained that Pembrokeshire and Derwen NHS Trust ('the First Trust') compromised her late father's rehabilitation. She said that it did not involve a stroke specialist or start mobility-related physiotherapy at the appropriate time. She complained that it mismanaged his discharge from hospital. She said that it did not make required referrals prior to his discharge, that it withdrew his inhalers and made a 'Nil by Mouth' decision, without explanation, shortly before its occurrence and that it failed to inform her of discharge-related funding issues promptly. She complained that it undermined her ability to identify an appropriate nursing home placement for him because it did not inform her of, and explain, his Temazepam prescription. She said that Hywel Dda NHS Trust ('the Second Trust') made false allegations against her when responding to her complaint. She suggested that these allegations compromised the independent review process. She complained that the Second Trust and Hywel Dda Health Board ('the Health Board') had not substantiated them,

issued a retraction or provided a written apology for them. She also complained that the Health Board had not supplied information, which it had agreed to provide during local resolution meetings.

The Ombudsman partly upheld every aspect of Ms P's complaint. He recommended that the Health Board should apologise for the failings identified. He asked it to remind staff members that they should only prescribe Temazepam in accordance with the relevant advice. He recommended that it should develop a mechanism for improving its legal advice records. He asked it to prepare a statement, for its complaint file, that recognises the deficiencies in some of its content. He recommended that it should supply details of its training relating to the preparation of complaint file statements. The Health Board agreed to comply with these recommendations.

**Case reference 201100477**

**July 2012 – Appointments/admissions/discharge/transfer procedures – Hywel Dda Health Board**

Mrs C complained that she was inappropriately discharged home from Withybush Hospital by a Consultant Surgeon in October 2010. She was readmitted to Hospital two days later after losing consciousness. Mrs C was later diagnosed with a heart problem which required the fitting of a pacemaker. She considered that the heart problem should have been identified in October 2010. Mrs C also felt the Consultant Surgeon's attitude was unacceptable.

The Ombudsman found that the decision to discharge Mrs C was clinically reasonable. There was also no evidence during the admissions in October 2010 that Mrs C had suffered a heart attack. The Ombudsman was unable to reach a decision on the attitude of the Consultant Surgeon, although he did consider that the standard of communication with Mrs C could have been better, particularly in relation to arrangements for further investigations to be done in outpatients. To that limited extent only he upheld the complaint.

**Case reference 201102387**

**Other reports – Not Upheld**

**January 2013 – Clinical treatment outside hospital – Hywel Dda Health Board**
Mrs J complained that she was unhappy about the management of her pregnancy, particularly in its latter stages, believing this led to the unfortunate still birth of her son. Earlier in her pregnancy it was identified that the umbilical cord only had two blood vessels, which is not usual. Consequently, Mrs J considered that the she should have been induced, as opposed to being allowed to go beyond her due date, and so felt her baby might have lived. She was unhappy with the results of the Health Board's own investigation of events that could not answer why her baby had not survived.

The investigation found that Mrs J had been managed in accordance with good practice throughout. There was no clinical reason to induce Mrs J sooner, as she believed. She had been assessed and monitored (through blood tests and Cardiotocograph traces) by a Consultant at the hospital, including being offered additional scans and appointments some of which she failed to keep. There were no recorded concerns. Mrs J was subsequently seen daily at home by a community midwife (beyond her due date) and no problems were noted (by either the midwife or Mrs J) until Mrs J reported feeling no foetal movement, whereupon she was immediately admitted to hospital. Sadly, the baby had died. Mrs J declined a post mortem. The Ombudsman's clinical advisers confirmed that whilst not usual, an umbilical cord with two vessels causes no ill effect in most pregnancies. In those where it does cause problems, such issues, and any other reason for the stillbirth, could not be identified from Mrs J's records. Only a post mortem might definitively establish the cause. Whilst recognising the distressing outcome for Mrs J, the Ombudsman did not uphold her complaints.
**Case reference 201200975**

**October 2012 – Continuing care – Hywel Dda Health Board**
Mrs A complained about the decision of the Health Board not to grant her late father in law, Mr T, Continuing healthcare funding for the duration of his stay at a care home and that his primary care had been health care, not social care. She complained about the conduct of the Home's staff and that several months of Mr A's medical notes were missing. Mrs A's Advocate raised the point that there had not a proper assessment of Mr A prior to his admission to the home.

Mr T's case had been considered by a Review Panel. It had taken account of the missing notes and had decided that Mr T's primary need was for social care rather than health care. The staff conduct had been considered by other organisations. At the time that Mr T was in the home, it was not uncommon that proper assessments prior to admission were not conducted. These shortcomings were recognised by the Welsh Government who issued new Guidelines which made provision for retrospective reviews. The Ombudsman did not uphold this complaint.
**Case reference 201103961**

**July 2012 – Clinical treatment in hospital – Hywel Dda Health Board**
Ms B complained about the standard of care and treatment provided to her by the Health Board. Specifically she complained that clinicians had failed to diagnose the cause of her right sided pelvic pain when she was in hospital in May 2011. She was

subsequently readmitted as an emergency in August 2011 and had her appendix removed. This alleviated her pain. Mrs B's appendix was inflamed on removal, but was found not to be acutely infected. She felt that the operation could have been done several months earlier and complained that she was left in pain for longer than was necessary.

The Ombudsman sought clinical advice on the complaint. The adviser noted that there were no clinical signs of acute infection during Mrs B's admission in May, but these signs were present at the August admission. The adviser noted that Mrs B's pain could have resulted either from pelvic inflammatory disease or appendicitis; it was impossible to reach a definite diagnosis. The care and treatment provided to Mrs B had been appropriate given her presenting symptoms and clinical history. The Ombudsman did not uphold the complaint.

**Case reference 201103595**

**May 2012 – Clinical treatment in hospital – Hywel Dda Health Board**

Mrs A's complaint related to the care and treatment that she received at Withybush Hospital during January 2009. She complained that a misdiagnosis (specifically a failure to recognise that her Achilles tendon was partially torn) meant that there was a delay in her receiving appropriate treatment. As a consequence of this Mrs A indicated that she had suffered permanent damage to her left leg.

The investigation found that the diagnosis of Achilles tendon injury was clearly considered at both Ms A's initial visit to A&E and later at Fracture clinic. Taking account of the clinical advice received, it was judged that this injury was acceptably ruled out from Mrs A's clinical presentation at the time. A diagnosis of gastrocnemius muscle tear was instead made. It was identified that the initial treatment provided to Mrs A was appropriate and would be the same for a partial tear of an Achilles tendon or gastrocnemius.

Over time, the Health Board identified that Mrs A's Achilles tendon had completely ruptured. At that point appropriate care and treatment was offered and Mrs A underwent surgery. The investigation found that there was no evidence to suggest that there was mismanagement of Mrs A's situation or that an operation had been indicated at a much earlier stage.

It was considered likely that Mrs A suffered a partial Achilles tendon rupture at the outset (which reasonably had not been identified) which later went on to become the complete rupture. It was noted that the lack of clarity provided to Mrs A by the Health Board around when the full rupture might have occurred had not helped in the understanding of her situation.

Overall however the Ombudsman was of the view that Mrs A received satisfactory care and treatment and her complaint was not upheld. The Ombudsman in light of a delay in the complaint response from the Health Board to Mrs A invited it to ensure that its complaint procedure was fully in line with the Model Complaints Policy and Guidance for Public Services in Wales. The Health Board were also invited to review the adequacy of clinical record keeping at patient consultations.

**Case reference 201100909**

## Quick fixes and Voluntary settlements

**January 2013 – Clinical treatment in hospital – Hywel Dda Health Board**
Mr J contact my office to advise that an appointment with Bronglais Hospital Urology Department that morning, but that he was housebound and reliant on a friend to take him to the appointment. However, the friend could not take him until that afternoon. Mr J advised that he had tried to contact the Hospital on the number provided to change the appointment, but had been unable to speak to anyone. Mr J was concerned that he would miss his appointment and would then have to wait a long time for a new one.

My office contacted the Health Board, which subsequently arranged a new appointment and informed Mr J of the date and time of the new appointment.
**Case reference 201203739**

**December 2012 – Clinical treatment in hospital – Hywel Dda Health Board**
Mrs J's complaint related to a sterilisation procedure carried out at the time of her caesarean section in 2000 and the management of her subsequent ectopic pregnancy in 2010. In particular, she complained that the procedure was incorrectly performed which resulted in the ectopic pregnancy. She also complained about the information provided to her at the time of her sterilisation and the way in which the Health Board obtained her consent to the procedure. Finally, she complained that her consultant was unable to reassure her that she would not become pregnant in the future which she said led to her decision to undergo a hysterectomy.

The Ombudsman did not uphold the complaint. Having sought advice from a consultant in obstetrics and gynaecology, it was confirmed that the procedure had been correctly performed and that an ectopic pregnancy is a well known risk of sterilisation. The evidence confirmed that Mrs J was provided with adequate information about the sterilisation in accordance with national guidance in 2000, that her consent was obtained in a reasonable manner and that the follow up care after her ectopic pregnancy was appropriate.
**Case reference 201200032**

**November 2012 – Clinical treatment in hospital – Hywel Dda Health Board**
Mrs T's complaint was in relation to the care she and her family have received from the Health Board in recent years. Mrs T originally complained to the Health Board in January 2012 and received a response dated 21st May 2012. In her complaint to the Ombudsman she said she was dissatisfied with the Health Board's response, and subsequently wrote again to the Health Board on 15th October 2012. Mrs T was yet to receive a response from the Health Board to her letter dated 15th October 2012. On receiving Mrs T's complaint, my office contacted the Health Board which confirmed the date by which it intended to respond.
**Case reference 201202852**

**October 2012 – Clinical treatment in hospital – Hywel Dda Health Board**
Mr. J complained about Hywel Dda Local Health Board ("the Health Board") ophthalmic services. Mr. J was referred for a second cataract removal on his left eye in January 2011 by his optician. The Health Board refused to treat Mr. J on the basis that his cataract was not a sight threatening condition and his level of vision with

both eyes open was considered acceptable without surgery. Mr. J complained that the Health Board's decision failed to take account of his personal circumstances. Mr. J is a church organist and as a result of his condition has to close his left eye to read music.

As part of the investigation of the complaint information was obtained from the Health Board concerning its protocol for considering referrals and clinical advice was received from one of the Ombudsman's professional advisers, a Consultant Ophthalmologist. On the basis of the evidence and advice received the Ombudsman concluded that the Health Board had failed to make a reasonable and informed decision when it refused Mr. J an appointment/treatment in January 2011, as its referral protocol did not allow for consideration to his special circumstances and the effect of the cataract on his vision.

The Ombudsman determined that the circumstances of the complaint were such that prompt action could be taken by the Health Board to resolve the matters for Mr. J. The Health Board agreed to undertake an urgent review of Mr. J's case giving due consideration to his special circumstances, review and amend its protocol for considering referrals to allow for consideration of special circumstances and the effect on a patients vision and to make a payment of £100 to Mr. J in respect of his time and trouble in pursuing this complaint.

The Health Board has also in recent times taken measures to increase its service provision.

**Case reference 201102055**

**October 2012 – Clinical treatment in hospital – Hywel Dda Health Board**

The complainant complained she had not received a response to her complaint, forwarded to the Health Board by PSOW on 24 July 2012. My office contacted the Health Board which, although it had written a response on 22 August 2012, had failed to send the response. The response was subsequently sent with a covering letter offering an 'unreserved apology'.

**Case reference 201202524**

**August 2012 – Clinical treatment in hospital – Hywel Dda Health Board**

Mr D complained about the treatment his wife received whilst a patient in hospital. Mr D raised concern at the time taken to respond to various correspondence.

On receiving Mr D's complaint, my office contacted Hywel Dda Health Board which agreed to contact Mr D that day by email or telephone to discuss his complaint and the best way forward as the Health Board required further information before it could respond to the complainant. The complainant called back to confirm the Health Board had contacted him and both parties had come to an agreement.

**Case reference 201201836**

**August 2012 – Complaint-handling – Hywel Dda Health Board**

My office received a complaint from Mrs P which related to a complaint her daughter had made in January 2012. Her daughter's complaint related to the care and treatment of her husband, Mr P, who sadly passed away at the beginning of January 2012. Mrs P was concerned that she still had not received her final response/report.

My office contacted the Health Board, who said that they had contacted Mrs P regarding the delay with her complaint. The Health Board advised it had further queries regarding the final response and needed to address those queries before sending out the response. Although the Health Board said that the response should be issued shortly, my office requested that the Health Board keep Mrs P informed of any further delay with the final response.
**Case reference 201201669**

**April 2012 – Clinical treatment in hospital – Hywel Dda Health Board**
The Ombudsman received a complaint from Mrs E. Mrs E's complaint was in relation to the manner in which she claimed she was spoken to by Dr X regarding her late father, and her concern for his care whilst a patient at Bronglais Hospital. Mrs E was also unhappy as she was still awaiting a final response from the Health Board. On receiving Mrs E's complaint, the Ombudsman's office contacted the Health Board to enquire as to when a response would be sent to Mrs E. The Health Board said that Mrs E's complaint was still being investigated.

On receiving this information, the Ombudsman asked the Health Board to write to Mrs E acknowledging the delay in responding to her complaint, apologise for the delay, and to confirm that it was currently dealing with the matter and respond within two weeks. The Health Board agreed to this action, therefore the file on Mrs E's complaint was closed based on this.
**Case reference 201103766**

**May 2012 – Complaint-handling – Hywel Dda Health Board**
The Ombudsman received a complaint from Mrs E. Mrs E was unhappy as she had not received the response from the Health Board which it had agreed to send her (reference 3466/201103766) in relation to her previous complaint.

The Health Board was contacted. It said that there had been a delay in responding to Mrs E and, at the time, it could not provide a definitive date for a response to be sent to Mrs E. The Ombudsman asked it to write to Mrs E explaining the reasons for the delay and to once again apologise. After further correspondence with the Health Board, it agreed to provide Mrs E with a final response within 10 working days. Based on this action, the file on Mrs E's complaint was closed.
**Case reference 201200599**