

Our ref: PT/jm

Ask for: James Merrifield

Your ref:



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Date: 9 July 2013



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Mr Richard Parry Jones
Chief Executive
Isle of Anglesey County Council
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Dear Richard

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 Isle of Anglesey County Council.

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. Housing and planning are the next largest areas of complaint, however, planning complaints are noticeably fewer in number compared to housing for the first time since the office came into existence (accounting for 16% and 12% of the caseload respectively).

In reference to the overall performance of County/County Borough Councils in Wales, whilst there has been a 35% increase in the number of investigation reports issued by my office during 2012/13 compared with 2011/12, I am pleased to note that, despite this increase, there has been no increase in the average number of 'upheld' reports issued against County/County Borough councils. Whilst I have had cause to issue a number of Public Interest Reports identifying serious concerns and failings, these reports have all concerned health bodies. Nevertheless, I would urge all bodies in Wales to read the reports to learn any general lessons appropriate to the services they deliver.

I note that the average number of 'Quick Fixes' and 'Voluntary Settlements' achieved with local authorities has decreased compared with 2011/12, from 5 to 4 cases. Such settlements are an effective way to resolve complaints at an earlier stage and without the need for a full investigation. As such, 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 Council, there has been a decrease in the number of complaints received and investigated, compared with 2011/12, although both figures remain above the average. Whilst there has also been a decrease in the number of 'upheld' complaints compared with 2011/12, this figure also remains above the average. In reference to your Council's response times, it is disappointing to note that half of responses to requests for information from my office were received more than six weeks after they were requested.

As with previous exercises, a copy of this letter will also be published on my website. I would also be glad to meet with you to discuss the contents of this letter and the work of my office if you consider it beneficial.

Yours sincerely

Peter Tyndall
Ombudsman

Appendix

Explanatory Notes

Section A compares the number of complaints against the Council which were received by my office during 2012-2013, with the local authority average (adjusted for population distribution¹) during the same period.

Section B provides a breakdown of the number of complaints about the Council which were received by my office during 2012-2013. Section C compares the number of complaints against the Council which were received by my office during 2012-2013, with the local authority average for the same period. The figures are broken down into subject categories.

Section D provides the number of complaints against the Council which were taken into investigation by my office during 2012-2013. Section E compares the number of complaints taken into investigation with the local authority average (adjusted for population distribution) during the same period.

Section F compares the complaint outcomes for the Council during 2012-2013, 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 G compares the Council's response times during 2012-2013 with the average response times for all local authorities, 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.

Section H provides a breakdown of all Code of Conduct complaints received against Councillors during 2011-2012. Finally, Section 'I' contains the summaries of all reports issued in relation to the Council during 2012-2013.

Housing Stock

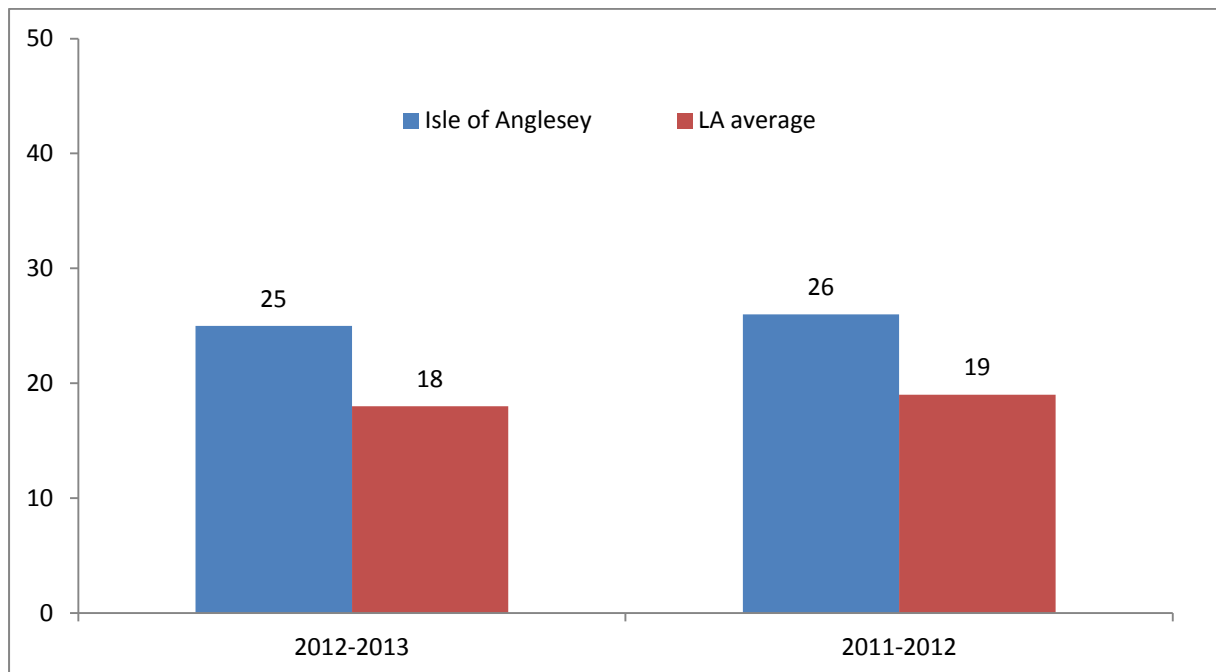
As with previous exercises, the figures for 2012-2013 have not been adjusted to take account of the transfer of housing stock. However, it is noted that there is likely to be a higher proportion of Housing complaints where local authorities have retained their housing stock.

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 james.merrifield@ombudsman-wales.org.uk.

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, adjusted for population distribution

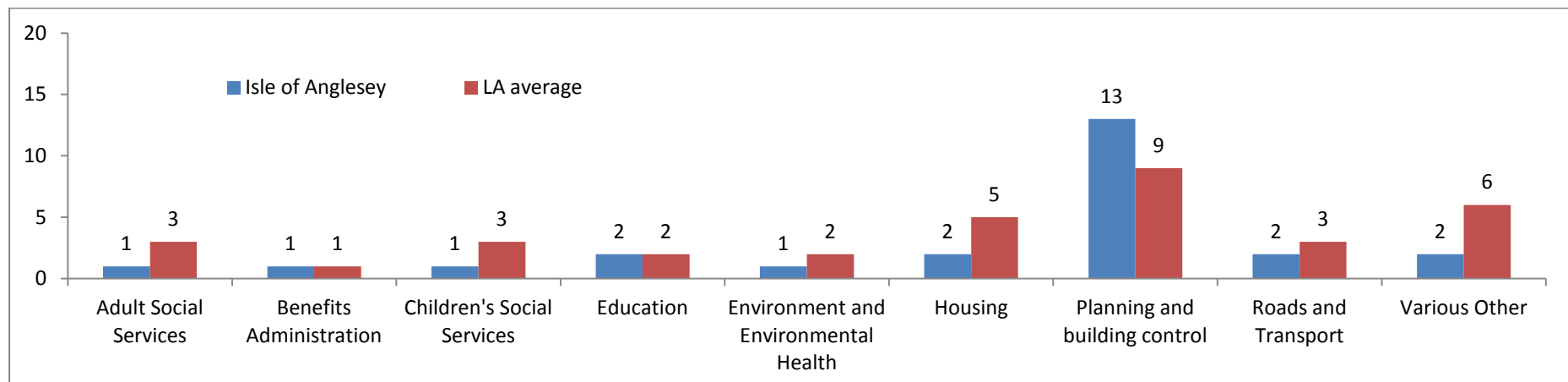


B: Complaints received by my office

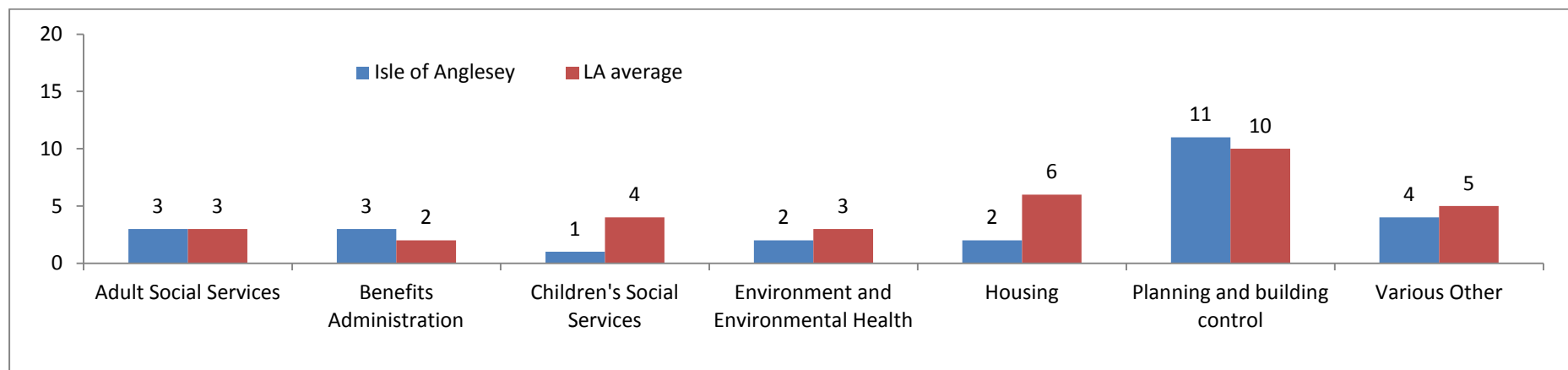
Subject	2012-2013	2011-2012
Adult Social Services	1	3
Benefits Administration	1	3
Children's Social Services	1	1
Education	2	0
Environment and Environmental Health	1	2
Housing	2	2
Planning and building control	13	11
Roads and Transport	2	0
Various Other	2	4
Total	25	26

C: Comparison of complaints by subject category with LA average

2012-2013



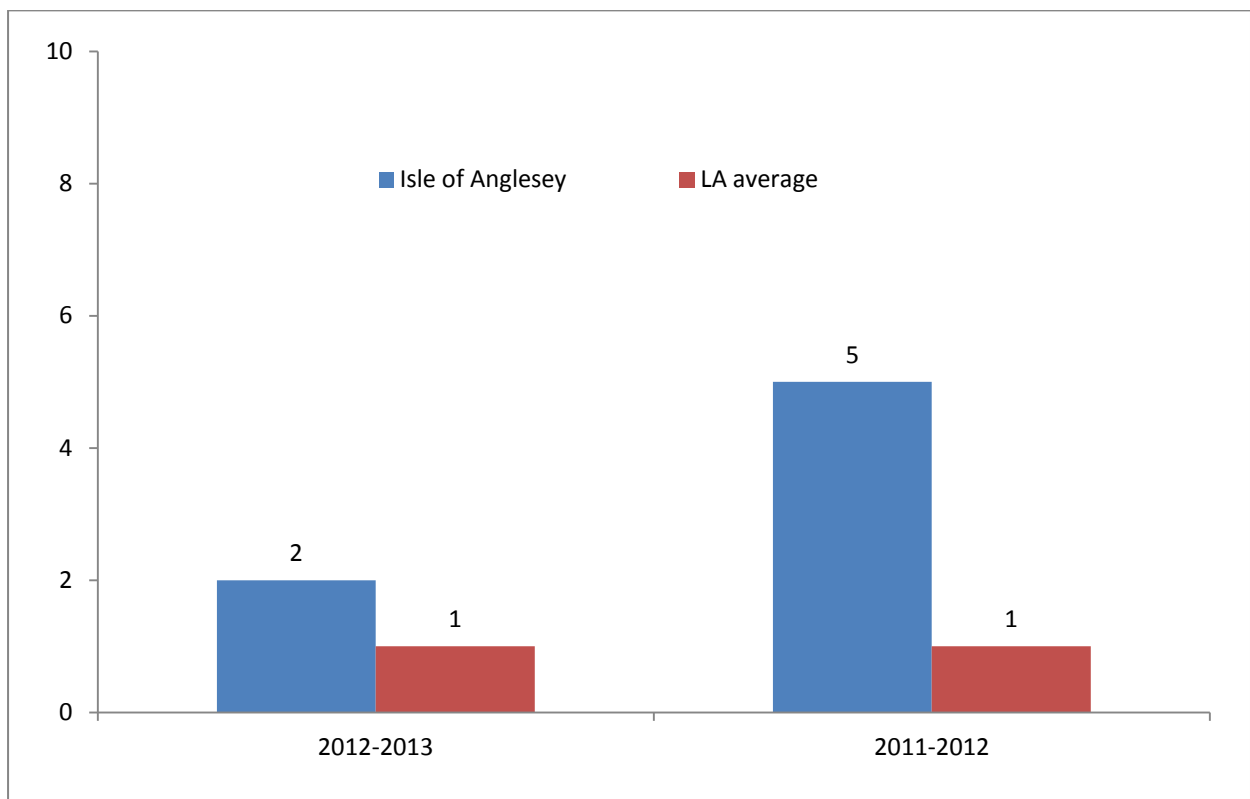
2011-2012



D: Complaints taken into investigation by my office

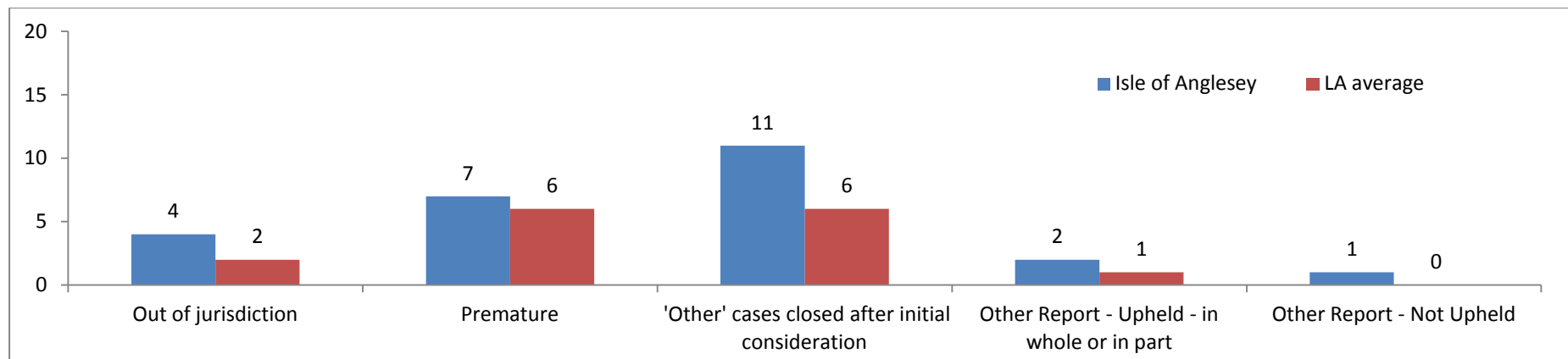
	2012-2013	2011-2012
Number of complaints taken into investigation	2	5

E: Comparison of complaints taken into investigation by my office with average, adjusted for population distribution

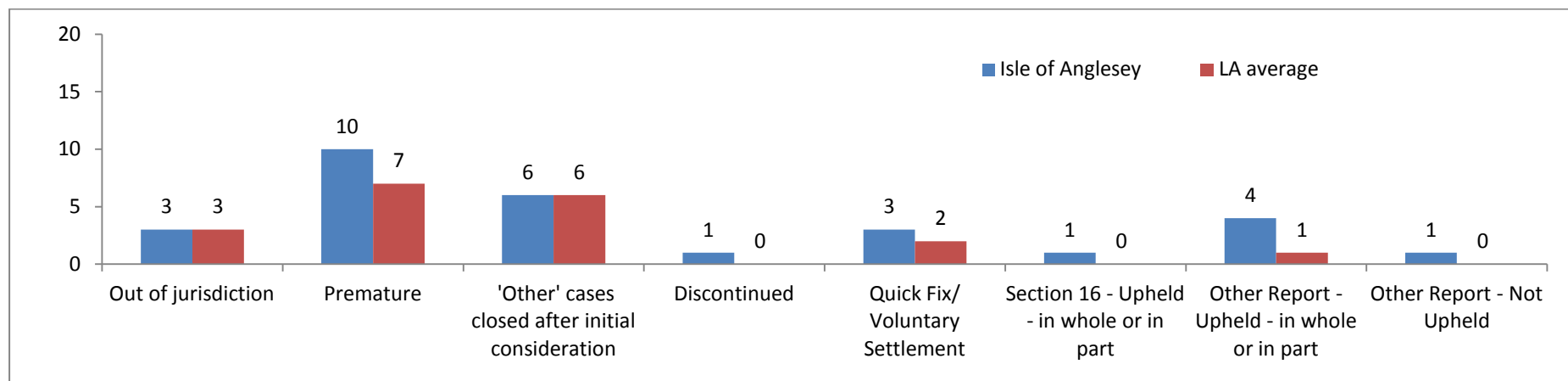


F: Comparison of complaint outcomes with average outcomes, adjusted for population distribution

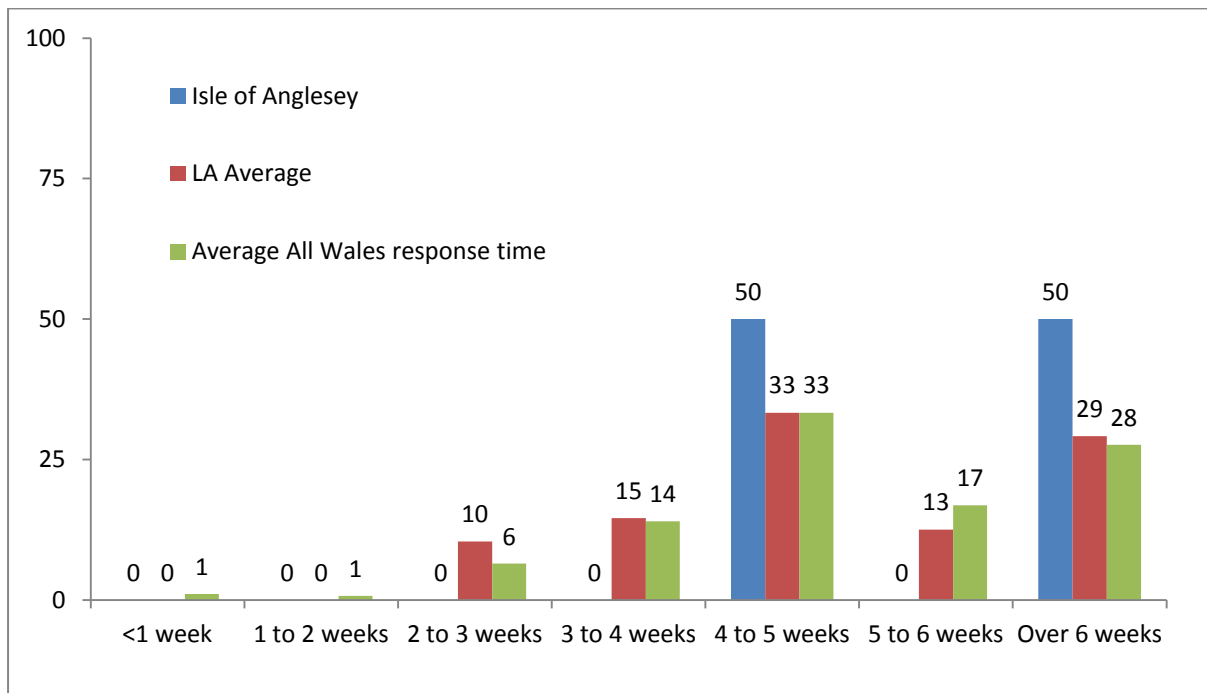
2012-2013



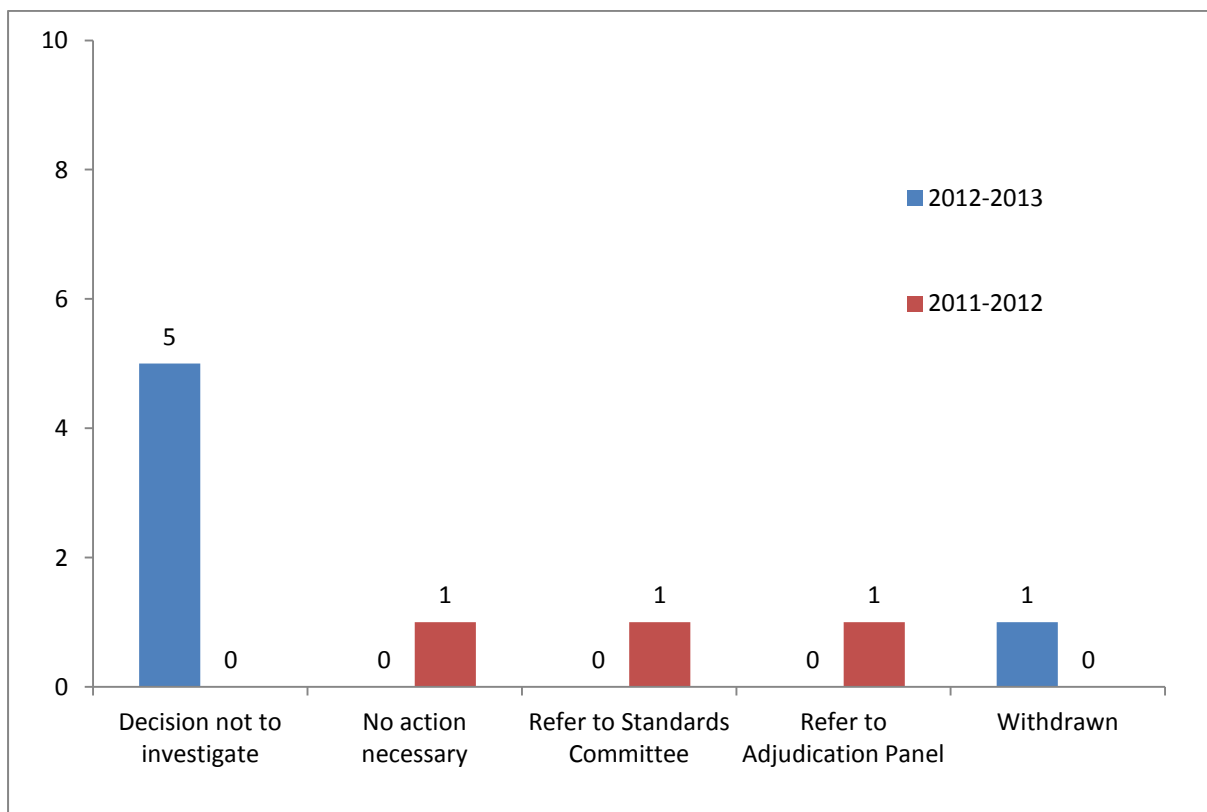
2011-2012



G: Comparison of Council times for responding to requests for information with average LA and average All Wales response times, 2012 – 2013 (%)



H: Code of Conduct complaints



I: Report summaries

Health

Upheld

October 2012 – Other – Betsi Cadwaladr University Health Board & Isle of Anglesey County Council

Ms A complained on behalf of her mother, Mrs B, and her uncle, Mr W, about the care and treatment provided to Mr W by the Isle of Anglesey County Council and Betsi Cadwaladr University Health Board. In particular, Ms A complained about the lack of communication with the family, specifically with her mother during Mr W's stay at a nursing home from July 2008 to February 2011, and following his admission to hospital on 21 February 2011.

The Ombudsman partly upheld the complaint. Having sought advice from a registered social worker, a registered mental health nurse and consultant psychiatrist, the investigation found that the level of communication with the family regarding Mr W's care was inadequate. Shortcomings in the Health Board's care and aftercare planning and in its record keeping were identified, in addition to a failure to respond to the initial complaint. Inadequacies in the Council's complaints handling and in its complaints policy were also highlighted.

The Ombudsman made a number of recommendations to address the failings identified, including that the Health Board and Council should apologise for the communication failings and agree that a joint response to such complaints will be provided in future cases. The Ombudsman also recommended that the Health Board should make a redress payment of £300 to the family for the failure to respond to the complaint, and take appropriate action to address any failings with regard to the Care Programme Approach.

Case reference 201101477 & 201101445

June 2012 – Clinical treatment outside hospital – Betsi Cadwaladr University Health Board & Isle of Anglesey County Council

Mr and Mrs A complained about the care and treatment provided to Mrs A's brother, Mr H, and the failure of the Health Board to deal adequately with their complaint.

In May 2009, Mr H was sectioned and detained at a local Psychiatric Unit. This followed concerns that Mr and Mrs A raised about Mr H not eating or drinking properly and neglecting himself. Mr H was diagnosed as having a severe depressive illness with psychotic symptoms. On receiving treatment his condition improved and he was discharged in July 2009.

Prior to leaving hospital, Mr H was placed on an enhanced care programme approach ("CPA"). The enhanced CPA is meant to reflect the fact that the individual requires greater intervention and a more comprehensive care plan in place to minimise the likelihood of relapse when they are back in the community. To help co-ordinate Mr H's care, a Social Worker ("the SW") from the Community Mental Health Team ("CMHT"), which consists of health and social services professionals, was appointed as Mr H's Care Co-ordinator. A key part of Mr H's care plan was that he would have

regular visits from the SW. Following three home visits to Mr H (in July and September), the SW's subsequent contact with Mr H were telephone calls. Following the SW's periods of illness, social work contact appears to have lapsed, although Mr H continued to attend his outpatient appointments with his Psychiatrist. In March 2010, following concerns raised by a neighbour, Mr H was found dead at home. The post-mortem findings found that he had died of a pulmonary embolism (where blood clots cause blockages of the blood vessels in the lungs) due to deep vein thrombosis.

The Ombudsman's investigation found evidence of systemic failings in the operation of the CMHT. Poor management controls had adversely affected how council staff, including the SW, operated within the CMHT. There was also a failure to take a cohesive multi-disciplinary approach to changes in Mr H's care plan. The Ombudsman's investigation concurred with a previous Health Board investigation that inadequate mechanisms were in place to ensure effective follow up of clients, such as Mr H, during the prolonged absence of the SW. Whilst the Ombudsman did not identify any issues with the clinical care provided to Mr H following his discharge, nevertheless, the Ombudsman had concerns about how effectively the health professionals and social workers within the CMHT had worked together to ensure that Mr H received co-ordinated care. In view of the shortcomings identified, the Ombudsman upheld Mr and Mrs A's complaint against the Council.

The Ombudsman was highly critical of the way that the Health Board had dealt with Mr and Mrs A's complaint. He highlighted inadequacies in the then Chief Executive's response to Mr and Mrs A. Of particular concern was that corporately the Health Board had compromised its ability to learn lessons from Mr and Mrs A's complaint by its approach of removing references to shortcomings (identified during the joint investigation between the Health Board and the Council), from the complaint response. As a consequence, Mr and Mrs A's concerns had not been properly addressed. The inadequacies in the Health Board's complaints handling process led the Ombudsman to uphold this aspect of Mr and Mrs A's complaint.

Amongst the Ombudsman's recommendations was that both the Council and the Health Board's Acting Chief Executives should apologise for the failings identified. In addition, recommendations were made to address the Health Board's poor complaints handling. This included the Health Board paying Mr and Mrs A redress of £500 to reflect the inconvenience caused to them as a result of the Health Board's failings.

The Ombudsman also recommended that both the Council and the Health Board should jointly identify any further lessons that could be learnt from this report and develop an action plan. Finally, the Ombudsman recommended that the Council and the Health Board develop a procedure for dealing with self-neglect cases.

Case reference 201100506 & 201100509

Planning and Building Control

Not Upheld

June 2012 – Handling of planning application – Isle of Anglesey County Council

Mrs C complained that the Council had not properly notified her of an amended planning application that a neighbouring developer had submitted for a block of flats. She also complained that the height of the block of flats had had an adverse effect on her privacy as she was now overlooked.

The Ombudsman having taken into account the advice of his Planning Adviser concluded that the Council had met the statutory requirement for notification of the development. The investigation found that the development as built did not concur with the original planning permission and the Council was addressing this separately. However, in terms of the original planning application the Ombudsman was satisfied that the Council had considered the residents' amenities including that relating to privacy. The Ombudsman highlighted some administrative shortcomings such as record keeping which the Council was taking steps to address. However, the Ombudsman did not feel that these shortcomings would have had any material or adverse effect on Mrs C's case and the decision to grant planning permission. Mrs C's complaint was therefore not upheld.

Case reference 201101519