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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint

By Mr B

against Hywel Dda University Health Board and

Cardiff and Vale University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201701479 & 201702267

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Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mr B.

Summary

Mr B complained that his son ("C") waited two and a half years for urgent paediatric surgery. Mr B said this was an unnecessary wait and had a significant impact on C's quality of life. C was 11 years old and a patient of Hywel Dda University Health Board ("the First Health Board") but as it did not deliver the service C required he was referred to Cardiff and Vale University Health Board ("the Second Health Board"). The Second Health Board determined C needed urgent surgery. C received surgery 151 weeks (two years ten months and twenty days) after he was referred for treatment. During that time C suffered frequent infections, which required antibiotic treatment, and needed an open wound on his side dressed three times per week.

The Ombudsman found that this delay was unacceptable; C should have been afforded greater clinical priority by the Second Health Board. The Second Health Board did not regularly review C and did not consider the impact C's condition had on his life. Further to this the Ombudsman found that the First Health Board should have provided Mr B with the details of a person he could contact if C encountered a delay with his treatment and that the Second Health Board did not inform the First Health Board that it could not meet the Welsh Government Target for RTT time in this case, and consequently alternative options for treatment were not considered.

The Ombudsman said that the impact of the delay in treating the debilitating condition, which could not improve without surgery, could not be underestimated and that C's human rights may have been compromised. Both the Health Boards accepted the findings in the report and acknowledged their role in the failings of this case.

The First Health Board agreed that within one month it would:

(a) Apologise to C for its part in the failings identified in this report and make a redress payment to him of £500 in recognition of the injustice he suffered as a result of its actions.

The First Health Board also agreed that within three months it would:

(b) Ensure that all patients referred for a service outside of the Health Board are provided with a point of contact at the First Health Board with whom they can raise concerns if the provider breaches (or indicates it will breach) the 36-week Welsh Government target.

(c) Ensure that if a patient, for whom it has commissioned care, advises the First Health Board that they have (or have been informed they will) wait beyond the 36-week Welsh Government target, a system is in place to ensure that alternative options are considered, based upon the merits of each case.

The Second Health Board agreed that within one month it would:

(d) Meet Mr B (and C, if he would like) to apologise for the failings identified in this report.

The Second Health Board also agreed that within three months it would:

(e) Undertake a review of the complete pathway of care C received since his initial referral to the Second Health Board, in 2009. Any further failings should be considered, along with those already identified in this investigation, using a process akin to the redress arrangements. This should include consideration of both the physical and psychological impact that the delay had on C.

(f) Create a process for paediatric surgery cases, which have been commissioned by another health board, which will trigger engagement with the commissioning health board, if the case is likely to breach the 36-week Welsh Government target, so that alternative options may be considered. It should also commence a review of the processes in place to alert the referring health boards in its other service areas.

(g) Undertake a retrospective audit of the management of all urgent referrals on the waiting list, made to the consultant referred to in this

case, since June 2014, using an Independent Consultant Paediatric Urologist. If it is established that the waiting list has not been appropriately managed, or there are other cases where, due to their circumstances, a patient should have been afforded greater clinical urgency, create an action plan to address the concerns.

(h) Refer this report to the Health Board’s Equality Manager and to the Quality, Safety and Experience Committee, to identify how consideration of human rights can be further embedded into waiting list decisions.

The Complaint

1. Mr B complained about the care his son ("C") received from Hywel Dda University Health Board ("the First Health Board") and Cardiff and Vale University Health Board ("the Second Health Board"). C waited two and a half years for urgent paediatric surgery (nephrectomy[1]) Mr B said this was an unnecessary wait and had a significant impact on C's quality of life.

Investigation

2. My Investigating Officer obtained comments and copies of relevant documents from both of the Health Boards and considered those in conjunction with the evidence provided by Mr B. I obtained advice from Mr Feilim Murphey a Consultant Paediatric Urologist. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. Mr B and the Health Boards were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant Legislation and Policies

4. The Human Rights Act 1998 ("HRA") incorporates the rights set out in the European Convention of Human Rights into British law. It requires public authorities to act in compliance with the HRA and to respect and protect human rights.

5. The HRA includes a number of rights set out as a series of Articles:

- Article 3 is the right not to be tortured or treated in an inhumane or degrading way and includes issues such as extended periods of intense physical or mental suffering. Inhumane or degrading treatment need not be intentional; it can include neglect of duties.

[1] surgical removal of a kidney

- Article 8 is the right to respect for private and family life, home and correspondence, and includes issues such as independent living, quality of life and ability to thrive.

6. Care was commissioned for C by the First Health Board using the Service Level Agreement ("SLA") between Welsh Health Specialised Services Committee ("WHSCC") and the Second Health Board ("The Provider").

7. The WHSCC SLA states that "it is the responsibility of the provider to deliver a 36-week referral to treatment time on a specialty by specialty basis. There may be specific specialties where the referral from the pathway is delayed to the extent that the provider is unable to deliver the 36-week requirement. In these instances, the provider must ensure engagement with the commissioner and the provision of sufficient information to enable appropriate remedial action to be taken across the pathway."

8. The Welsh Government's guidance, 'Rules for managing referral to treatment ("RTT") waiting times' ("the Rules") sets out that:

> 'When the patient's RTT period involves more than one LHB, accountability for performance against the targets will be shared across all LHBs involved.'

9. GMC Good Practice Guide to Delegation and Referral ("the GMC Guide) which came into effect on 22 April 2013, states that Referral is when you arrange for another practitioner to provide a service that falls outside your professional competence. It also says that when you refer a patient:

> 'You must make sure the patient is informed about who is responsible for their overall care and if the transfer is temporary or permanent. You should make sure the patient knows whom to contact if they have questions or concerns about their care.'

Relevant background information and events

10. On 24 June **2014,** C (aged 11), was admitted to Glangwili General Hospital ("the First Hospital") in the area of the First Health Board with an abdominal abscess (collection of pus which has built up within the tissue of the body). The abscess was drained and the following day the dressing was changed under general anaesthetic (medication induced controlled unconsciousness).

11. On 27 June, an MRI scan (using magnetic fields to produce detailed images) was undertaken. The scan revealed a 'shrunken and superinfected left kidney with a large abscess perforating through the abdominal wall to above the iliac crest' (top of the pelvis). C had a sinus[2] on his left hip which needed regular dressing. A referral was made to a consultant urologist.

12. On 4 July, C had a specialist kidney scan; this revealed that his right kidney was functioning normally, but his left kidney had no function.

13. On 3 October, C was seen by the Consultant Urologist. On 15 October, C was referred by the First Health Board to the Consultant Paediatric Surgeon ("the Surgeon") at the University Hospital of Wales ("the Second Hospital"), in the area of the Second Health Board. It was noted that C had a chronically (persistently) discharging abscess from a non-functioning left kidney which required regular dressing; a nephrectomy was recommended. There is no information in the records to suggest that the First Health Board advised Mr B to contact it should C experience a delay in treatment.

14. On 11 December, C was seen by the Surgeon and was diagnosed with Xanthogranulomatous Pyelonephritis (XGP), a rare, serious, chronic inflammatory disorder of the kidney. The need for surgery and potential complications were explained.

[2] an infected tract leading from a deep-seated infection and discharging pus to the surface

15. On 18 February **2015**, the Surgeon wrote to C's GP, he confirmed the diagnosis and said that C would be added to the waiting list for the nephrectomy.

16. On 10 September, C's GP wrote to the Surgeon, he advised that C was still undergoing dressing changes three times a week for the discharging sinus. C had frequent infections requiring antibiotics and a "mucky discharge". The GP said these symptoms and dressing changes had been going on for more than a year and he was keen to expedite the surgery. The surgeon responded on 5 October, he advised that C was on the urgent waiting list but that there were no theatre spaces before December. The Surgeon said that he was prioritising patients with salvageable but deteriorating kidney function over C who already had no function in his left kidney. The Surgeon said that the letter had been copied to the management at the second Health Board so that it was aware of the waiting list situation.

17. On 20 January **2016**, a further GP letter was sent to the surgeon requesting that surgery be expedited. In September C's AM wrote to the second Health Board raising a concern about the delay. On 26 September, the second Health Board wrote to the AM confirming the position that the Surgeon was unable to prioritise C, over patients with salvageable but deteriorating kidney function.

18. On 8 December, C received a letter advising him that his surgery was scheduled for 6 January **2017** and that he should submit a urine sample to his GP for analysis, ten days before the surgery. He had a positive infection result, C's GP sought advice from the Surgeon on appropriate antibiotics but before a response was received Mr B was informed by telephone that C's surgery was cancelled because of the infection.

19. On 24 January, the Surgeon responded to the GP. He set out that it would be difficult to eradicate infection because of his condition and that surgery would likely proceed even if there was a positive result.

20. On 30 March Mr B complained about the time C had waited for surgery. The surgery was rescheduled for 16 May. C submitted a urine

sample for analysis before the surgery, again it was established that infection was present but Mr B was advised the surgery would still go ahead.

21. On 16 May the second Health Board responded to Mr B's complaint.

22. On 17 May, a Nephrectomy was undertaken by the Surgeon at the second hospital.

Mr B's evidence

23. Mr B said when C was admitted to hospital in June 2014 they found a lump which had to be aspirated. This left C with a large open wound on his left side which required packing & dressing daily, which caused him a lot of pain and distress. After further tests, they found his left kidney was non-functional and he was referred to the Surgeon. Mr B said they were told that C needed his left kidney removed urgently. The sinus would not heal until he had his kidney removed so it was infected constantly needing to be dressed 3 times a week. It became normal for C to be on antibiotics.

24. Mr B said they contacted the Surgeon's office 12 weeks after the first appointment to be told C was on the urgent list but there was no date yet. They made numerous calls to the Surgeon's office over the months only to be told the same thing. Mr B said family life was very intense and stressful and it had a major impact on everybody in their family. Mr B said the family felt like life was on hold as they were unable to go away or undertake regular activities as C needed dressings changed three times a week.

25. Mr B said they were finally given a date for C's operation in January 2017. He said they arranged time off for both parents only to be told the day before that it had been cancelled because C had an infection. Mr B said this caused the family great upset, he said he and his wife were very upset at having to tell their son that the operation was cancelled as they knew he would be very upset, Mr B said they had to be strong for C but would cry when he went to bed knowing they could not help him.

26. Mr B said that they had to call the Surgeon's office regularly again but still were not given information about a new date. Mr B said they

contacted their AM who wrote to the Chief Executive of the Second Health Board only to be told that C remained on the urgent list. Mr B said that he received a call to tell him that C's operation would take place the day after his case was reported on local media. Mr B said following C's operation in May 2017 a weight was lifted off the family.

C's evidence

27. C said that he felt his life had been on hold waiting for the operation. He said he had to go to his local GP three times a week to get his dressings changed and the sinus swabbed, which was often very painful. C said he had to take a lot of antibiotics which was not pleasant and he was not able to go out with his friends. C said that while he was waiting for his operation he had been unable to do the things he enjoyed doing with his friends like playing football or going swimming and he could not join army cadets because he could not do any contact activities. C said this was very stressful for him and it was upsetting being told that he could not do things.

28. C said that the condition really affected his confidence. He said he became very self-conscious about his side as others would make remarks and some would try to hit him on his side purposefully knowing it would hurt him, so he stopped going out with his friends. C said he would constantly ask his parents when he would get his operation only to be told they did not know which made him very upset. C said he was relieved when he was finally offered an operation but became very sad and upset when it was cancelled. C said that since the operation he is slowly getting his confidence back and leading a 'normalish' life.

The First Health Board's evidence

29. The First Health Board said that it does not deliver the service which C needed. It therefore commissioned the care through the Second Health Board which is the provider of this service. It said the Second Health Board is responsible for the entire period of care from the RTT and, in accepting the case had agreed to keep the First Health Board informed of

C's progress. It said the Second Health Board, the GP and the family did not advise it of the delay in this case. The First Health Board said, had it been made aware of the delay it could have taken further action.

The Second Health Board's evidence

30. The Second Health Board, in its response to Mr B's complaint, said the consultants dictate which patients are treated on their theatre sessions and the Surgeon was unable to prioritise C above other patients. It said that C's operation was 'no more detailed' than planned, due to the delay, it was always going to be a difficult nephrectomy.

31. The Second Health Board said the first surgery had been cancelled in January because the infection increased the surgical risk. The Second Health Board acknowledged that no patient should wait more than 36 weeks from RTT, but clinical priority takes precedence when the waiting lists exceed the target; it acknowledged that C had waited significantly longer than hoped and apologised for this.

32. The Second Health Board confirmed that there was another Consultant Paediatric Surgeon with an interest in Urology in the Health Board but that the waiting time to see him would not have been different. The Second Health Board said that it has employed two more surgeons capable of undertaking urological procedures (recruitment for a third is ongoing) and it employed locum consultants in 2017 to reduce waiting times, and now no child will wait beyond 52 weeks.

33. The Second Health Board said that it would not have been beneficial to C to return to the Surgeon for updates and follow up appointments as there was no alternative treatment. It apologised that this had not been explained when the Surgeon met C in December 2014.

34. The Second Health Board said it would not routinely update the referring Health Board regarding the waiting list position. However, it did respond to the patient's requests to expedite the surgery. The Second Health Board initially said that C's circumstances did not support expediting his procedure. It said the Surgeon is the best person to prioritise the surgical cases on the waiting list.

35. The Second Health Board said, in its response to Mr B's complaint, that rescheduling C's operation in January 2017 was clinically appropriate, to allow an infection to settle down, after treatment, before proceeding with invasive surgery. The Second Health Board was not, during the course of the investigation, able to show who made the decision to cancel this operation. The Surgeon said he would probably have been aware of the decision but there is no record to reflect that the Surgeon was involved in the process.

36. During the investigation, the Second Health Board acknowledged that it had breached its duty of care towards C. The Surgeon said that at the time C was seen by him, his symptoms were stable but he acknowledged that he did not review C as he could have and C waited too long for his surgery. The Second Health Board said that it would welcome the opportunity to review C's care, including that which it delivered in 2009.

37. The Second Health Board said that it would also welcome the opportunity to meet Mr B, to apologise and discuss the changes which have arisen following this complaint. The Second Health Board also acknowledged that the investigation into the initial complaint was not of a good enough standard and it regretted that it did not reach this conclusion as part of that investigation. It also said that this case had highlighted a concern with the way it monitors waiting lists and whether consideration should be given to referring the patient to an alternative provider, if it is unable to provide treatment within a reasonable length of time.

Professional Advice

38. The Adviser said C waited too long for surgery. In early July 2014 C was proven to have a non-functioning kidney which was infected and discharging onto the skin. A referral to paediatric urology for definitive treatment should have occurred earlier than October. As stated by the doctors involved C's care, the only treatment plan which would succeed was a nephrectomy and drainage of abscess. Conservative management in XGP beyond the first few weeks has no role. Without surgery, the sinus and abscess would continue to drain and would not resolve. Only excision

of the infected kidney and the surrounding inflammatory tissue would improve the situation. Without surgery, there was no opportunity for C to recover.

39. The Adviser said XGP is a rare chronic severe inflammatory condition which affects the kidney. Symptoms and signs are frequently longstanding prior to diagnosis with evidence of chronic inflammatory disease, abnormal blood tests, anaemia, fatigue and pain being common. In reality, children with XGP are frequently thought to have a malignancy[3] as they are that sick prior to the correct diagnosis. The Adviser said the fact that the abscess/inflammation in the kidney was so large that it passed through the tissue surrounding the kidney and then the muscle of the abdominal wall to the skin was a sign of the significance of this disease and its impact on C.

40. The Adviser said C should have been treated faster than occurred. The two years plus delay was unacceptable. C had an on-going discharging abscess and chronically inflamed left flank for all this time. The size and impact of this disease being untreated on a child cannot be underestimated.

41. Although C had no salvageable function in the affected kidney the on-going inflammatory process and weekly visits to the GP demonstrated a chronic debilitating condition which should have been treated promptly. Conservative management has no role in this condition and surgery is the only option. One could argue that C was potentially the sickest person on the waiting list at the time. XGP's impact on the sufferer is similar to that of cancer's impact on a patient, thus he should have been prioritised for surgery.

42. The Adviser said, in summary, C had a very significant condition which required surgery to resolve. The failure to provide the operation in the appropriate 'urgent' time frame led to further suffering, oozing from the wound, failure to thrive and had a significant impact on the patient. It resulted in numerous GP visits, dressing changes and medical review each

[3] Cancer

week. C remained with a chronically infected kidney with a discharging sinus which would have been debilitating. The operation needed to occur promptly after diagnosis and the delay was unsupportable.

43. The Adviser said the gap between planning for surgery and surgery occurring was unacceptable and the patient should have been seen in the interim. The lack of a review facilitated the delay in surgery. Being placed on a waiting list for so long really did require a follow up to check disease progression. There are two documented letters from the GP service to the hospital trying to expedite the operation date to no effect.

44. The Adviser said failing to operate in a timely fashion meant that other options such as surgery in another centre should have been considered.

45. The Adviser said the decision to cancel the operation was confusing as it was, by definition, a chronically infected kidney. The urine result was always going to demonstrate evidence of bacterial growth and infection. It was unclear in the medical notes who decided to cancel the first operation due to the presence of the positive urine cultures.

Analysis and conclusions

46. Mr B complained that his son waited two and a half years for urgent paediatric surgery. This was an unnecessary wait and had a significant impact on his quality of life. I **uphold** this complaint.

47. C was first referred to a Consultant Urologist because of his condition on 27 June 2014. He waited two years ten months and twenty days for treatment (151 weeks). The Advice I have received on this is clear; this was an urgent case and such a delay for surgery was unacceptable.

48. The First Health Board said it transferred full care of C to the Second Health Board. The SLA between the two Health Boards says that commissioned care should be completed within the 36-week RTT time. The Rules state that when the patient's RTT period involves more than one LHB, accountability for performance against the targets will be shared across the LHBs involved. The First Health Board said there is no system

in place to monitor the time taken for referred patients to receive treatment and it would expect the provider or the patient to inform it of any concerns. The First Health Board also said it would have acted if concerns were raised.

49. There was an expectation by the First Health Board that the patient should report any delay to the Health Board. I could not see evidence in the records that the First Health Board followed the GMC guidance which says, when a patient is referred, they must make sure the patient is informed about whom to contact if they have questions or concerns about their care.

50. Whilst it is acknowledged that the Second Health Board did not advise the First Health Board of the delay, the First Health Board did not provide Mr B with the information he needed to pursue, with it, any concerns he may have had about the delay. In the absence of a commissioning system which monitors referred patients, this information is essential. The Rules clearly indicate that both Health Boards are accountable, and the First Health Board acknowledges it would have acted had it been aware that there was an issue; I would suggest that this is an acknowledgement that it retained some responsibility for the patient. Failing to inform Mr B that, had there been a concern about the referral made for C, he could contact the First Health Board, amounts to service failure.

51. I am of the view that if Mr B had been aware of a contact at the First Health Board with whom he could have discussed his concerns about the delay, he would have done so. The First Health Board said if it had been aware of the delay it would have acted. The Health Board could have reviewed the patient and recognised the debilitating nature of the condition; this may have resulted in discussions with the Second Health Board to prioritise the surgery, or arrangements to commission the service from an alternative provider, to prevent further injustice to C which had been caused by the delay. The uncertainty that arises from not knowing whether a review by the First Health Board may have resulted in earlier treatment, is an injustice to C.

52. I am concerned that the Second Health Board relied entirely on the discretion of a single clinician when determining the priority of the cases on his list. The Adviser said that C could potentially have been the sickest person on the waiting list as XGP's impact on the sufferer can be similar to the impact cancer has on a patient, thus he should have been reviewed and prioritised for surgery. The delay is unacceptable and cannot be supported.

53. The Second Health Board said it prioritised patients who had deteriorating but salvageable kidney function over C because he had no function in the affected kidney. This indicates that the surgeon did not fully consider the impact of the condition, of which non-functioning kidney was only a part, on the patient. The Surgeon said he considered the requests to expedite C's surgery. However, he did not further review C's condition by examining him again. The Adviser said that the lack of review to check disease progression facilitated the delay.

54. I consider it to be unacceptable that, whilst the Second Health Board was aware of the significant delay in this type of surgery, it did not engage with the First Health Board to consider other options for this young patient who was suffering debilitating symptoms while languishing on the waiting list. The SLA clearly states it is the responsibility of the provider to deliver a 36 week RTT time and if this cannot be met, the provider must ensure engagement with the commissioner. I note that the Second Health Board now recognises that this is a significant issue which it will act upon. It is my view, that failing to engage with the First Health Board was a serious failing which meant that the patient suffered a significant injustice.

55. The impact of the delay in this case cannot be underestimated; C was an 11-year-old boy (at the start) who was unable to thrive for almost three years. The condition he had was debilitating with no chance of improvement without the surgery. The clinician responsible for prioritising the waiting list did not review C following his initial appointment.

56. Human Rights are underpinned by core values of fairness, respect, equality, dignity and autonomy ("FREDA"). These principles are fundamental to good public service delivery and as the Public Services Ombudsman for Wales, I have a role in promoting the human rights of

ordinary people in their dealings with public services in Wales. Central to applying human rights in practical terms is the recognition of a patient as an individual and delivery of care that is appropriate to them and which takes account of their needs.

57. Where I find evidence of service failure which has caused injustice, it is appropriate for me to consider whether a person's human rights may have been engaged and/or compromised as a result. I conclude that, in this case, C's human rights are likely to have been compromised. The failure to treat C in a reasonable amount of time meant that he was unable to live the normal life of a teenage boy. He was constantly on antibiotics and needed dressing changes three times a week. The Second Health Board failed to consider the impact the condition was having on C's life when determining his priority on the waiting list.

58. It is therefore apparent that C's human rights under Article 8 were engaged as a consequence of the failings I have identified; this is due to the extent that his life was affected in the two years he waited for treatment, beyond the 36-week target waiting time.

59. I am aware that the test for whether Article 3 was engaged has a very high threshold in the courts. I am not able to say with certainty that a court would find that C's Article 3 rights had also been affected. However, given the age of C, the time he waited for his treatment and the extent of his suffering, due to the impact on both his physical and mental wellbeing, I consider that the evidence is finely balanced and that it might do so. I consider my findings in this case to be very serious.

Recommendations

60. I **recommend** that within one month the First Health Board should:

(a) Apologise to C for its part in the failings identified in this report and make a redress payment to him of £500 in recognition of the injustice he suffered as a result of its actions.

61. I **recommend** that within three months the First Health Board should:

(b) Ensure that all patients referred for a service outside of the Health Board are provided with a point of contact at the First Health Board with whom they can raise concerns if the provider breaches (or indicates it will breach) the 36-week Welsh Government target.

(c) Ensure that if a patient, for whom it has commissioned care, advises the First Health Board that they have (or have been informed they will) wait beyond the 36-week Welsh Government target, a system is in place to ensure that alternative options are considered, based upon the merits of each case.

62. I **recommend** that within one month the Second Health Board should:

(d) Meet Mr B (and C, if he would like) to apologise for the failings identified in this report.

63. I **recommend** that within three months the Second Health Board should:

(e) Undertake a review of the complete pathway of care C received since his initial referral to the Second Health Board, in 2009. Any further failings should be considered, along with those already identified in this investigation, using a process akin to the redress arrangements. This should include consideration of both the physical and psychological impact that the delay had on C.

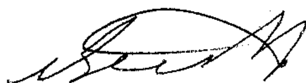
(f) Create a process for paediatric surgery cases, which have been commissioned by another health board, which will trigger engagement with the commissioning health board, if the case is likely to breach the 36-week Welsh Government target, so that alternative options may be considered. It should also commence a review of the processes in place to alert the referring health boards in its other service areas.

(g) Undertake a retrospective audit of the management of all urgent referrals on the waiting list, made to the consultant referred to in this case, since June 2014, using an Independent Consultant Paediatric

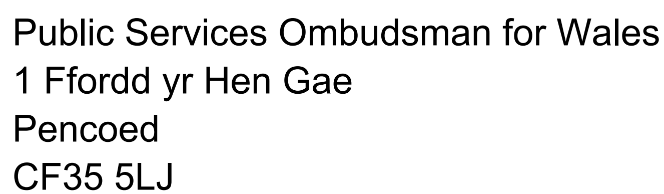
Urologist. If it is established that the waiting list has not been appropriately managed, or there are other cases where, due to their circumstances, a patient should have been afforded greater clinical urgency, create an action plan to address the concerns.

(h) Refer this report to the Health Board's Equality Manager and to the Quality, Safety and Experience Committee, to identify how consideration of human rights can be further embedded into waiting list decisions.

64. I am pleased to note that in commenting on the draft of this report Hywel Dda University Health Board and Cardiff and Vale University Health Board have agreed to implement these recommendations.



Nick Bennett Date 13 July 2018
Ombudsman



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