Our ref: PT/jm
Ask for: James Merrifield

Your ref:
01656 644 200

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

Dr Andrew Goodall
Chief Executive
Aneurin Bevan LHB
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Dear Andrew

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 Aneurin Bevan 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, although this figure is below the average. As with 2011/12, the largest area of complaint remains 'clinical treatment in hospital'. Whilst my office has taken more complaints into investigation compared with 2011/12, this is also below the average. In reference to complaint outcomes, there has been a large increase in the number of 'upheld' reports issued by my office, which remains at the same level as the average. However, it has been necessary for my office to issue one Public Interest Report in relation to your Health Board. It is disappointing to note that half of your Health Board's 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, Aneurin Bevan 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.

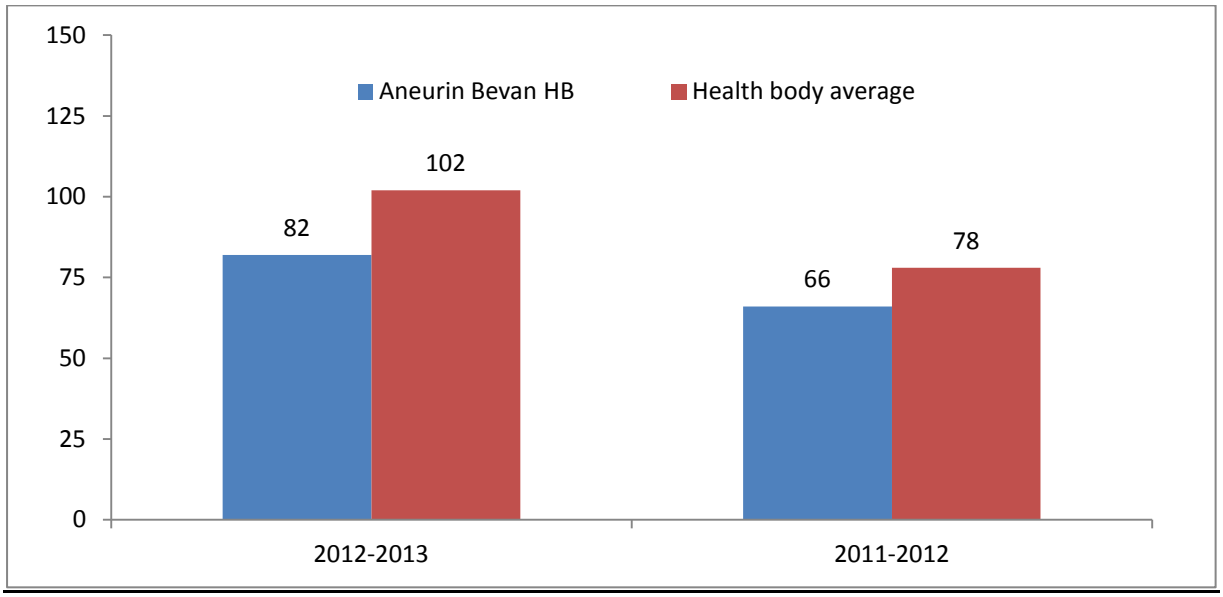
Section F compares the complaint outcomes for the Health Board during 2012-2013, with the average outcome for health bodies during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

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

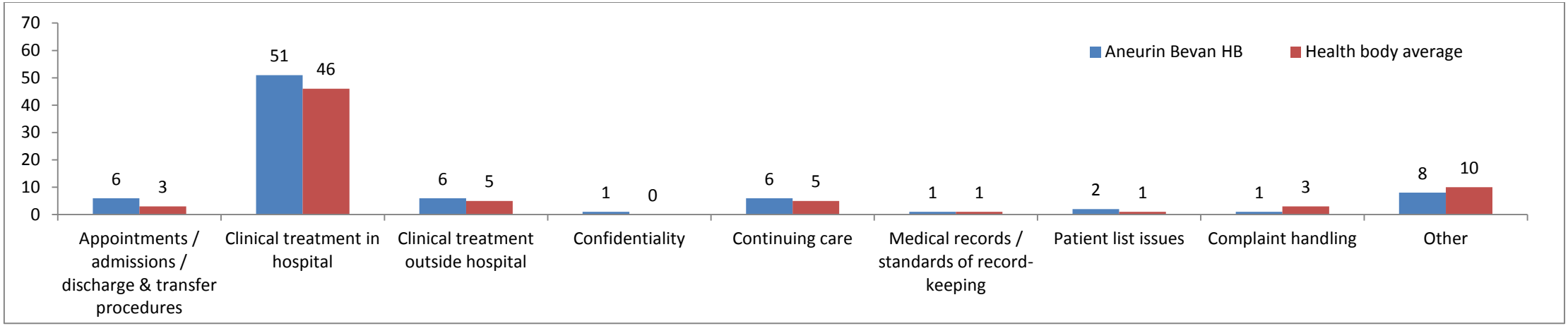


B: Complaints received by my office

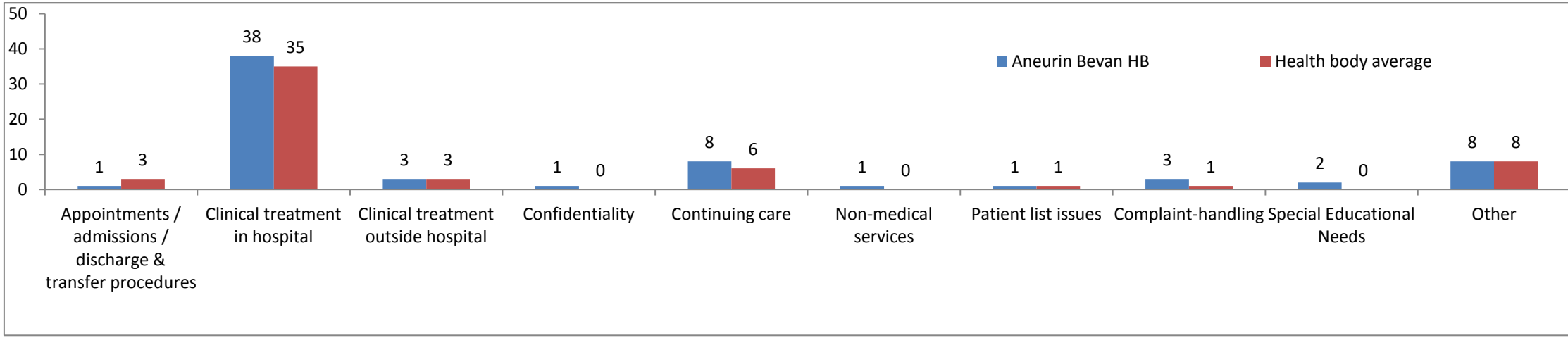
Subject	2012-2013	2011-2012
Appointments/ Admissions/ Discharge and transfer procedures	6	1
Clinical treatment in hospital	51	38
Clinical treatment outside hospital	6	3
Confidentiality	1	1
Continuing care	6	8
Medical records/ standards of record-keeping	1	0
Non-medical services	0	1
Patient list issues	2	1
Complaint-handling	1	3
Special Educational Needs	0	2
Other	8	8
TOTAL	**82**	**66**

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

2012-2013



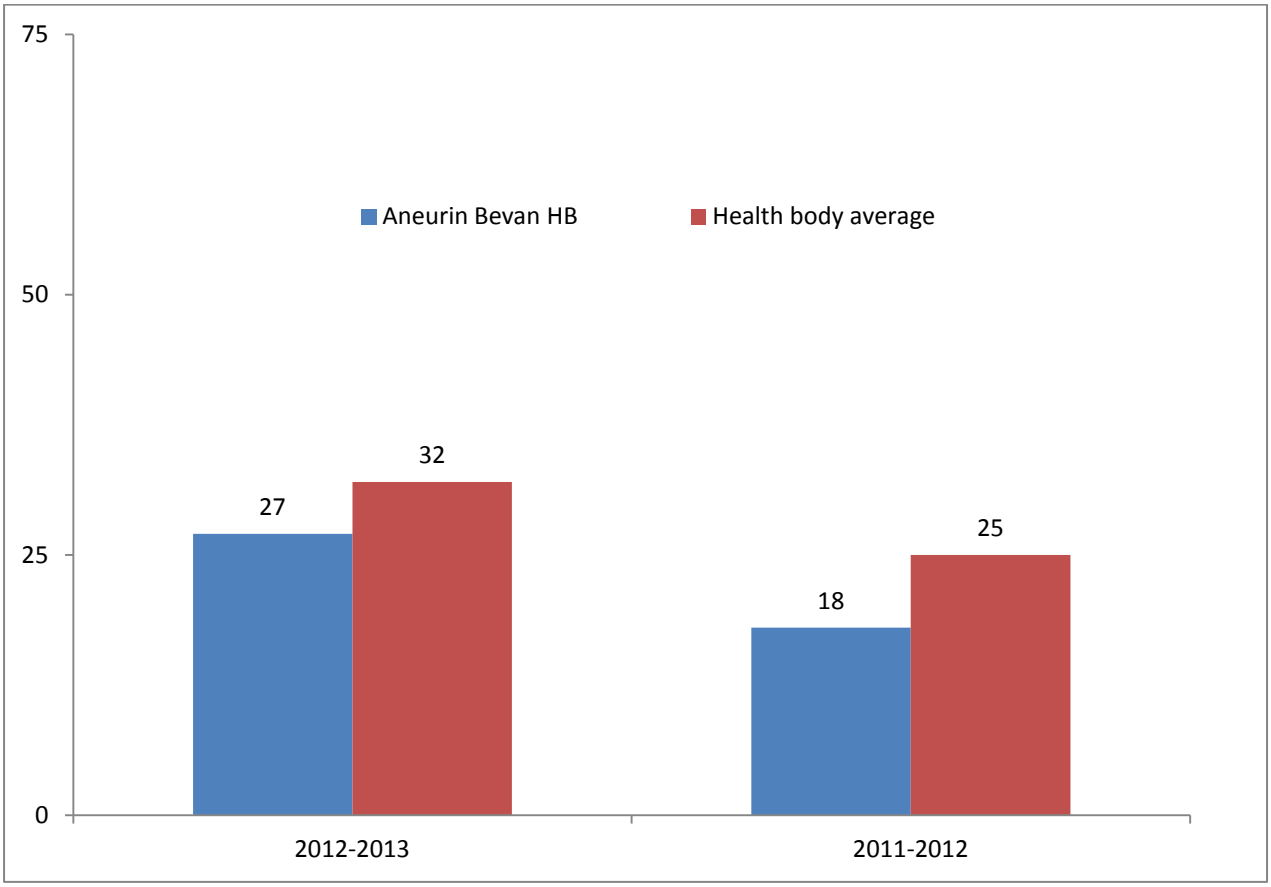
2011-2012



D: Complaints taken into investigation by my office

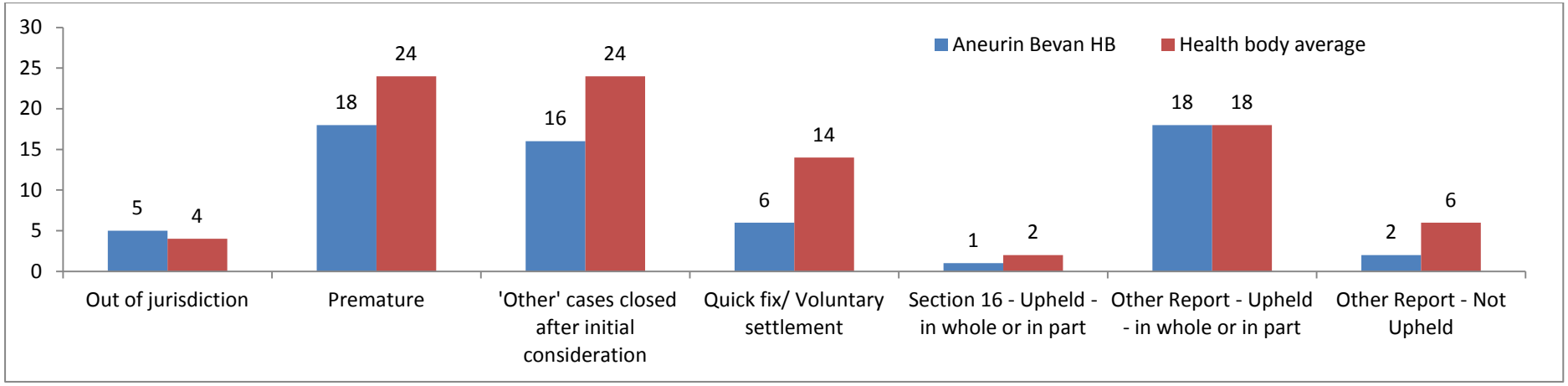
	2012-2013	2011-2012
Number of complaints taken into investigation	27	18

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

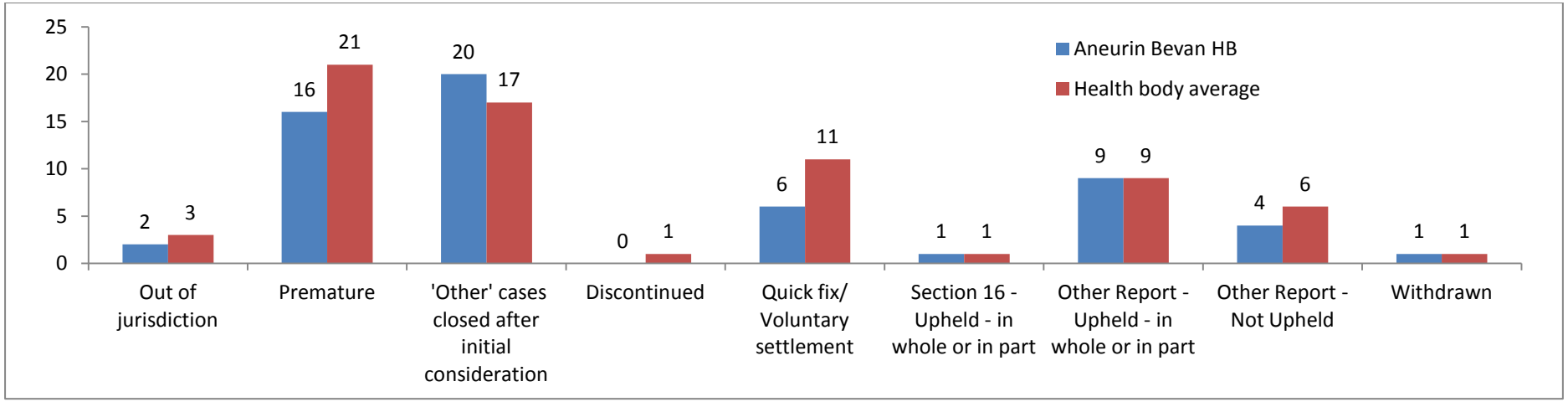


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

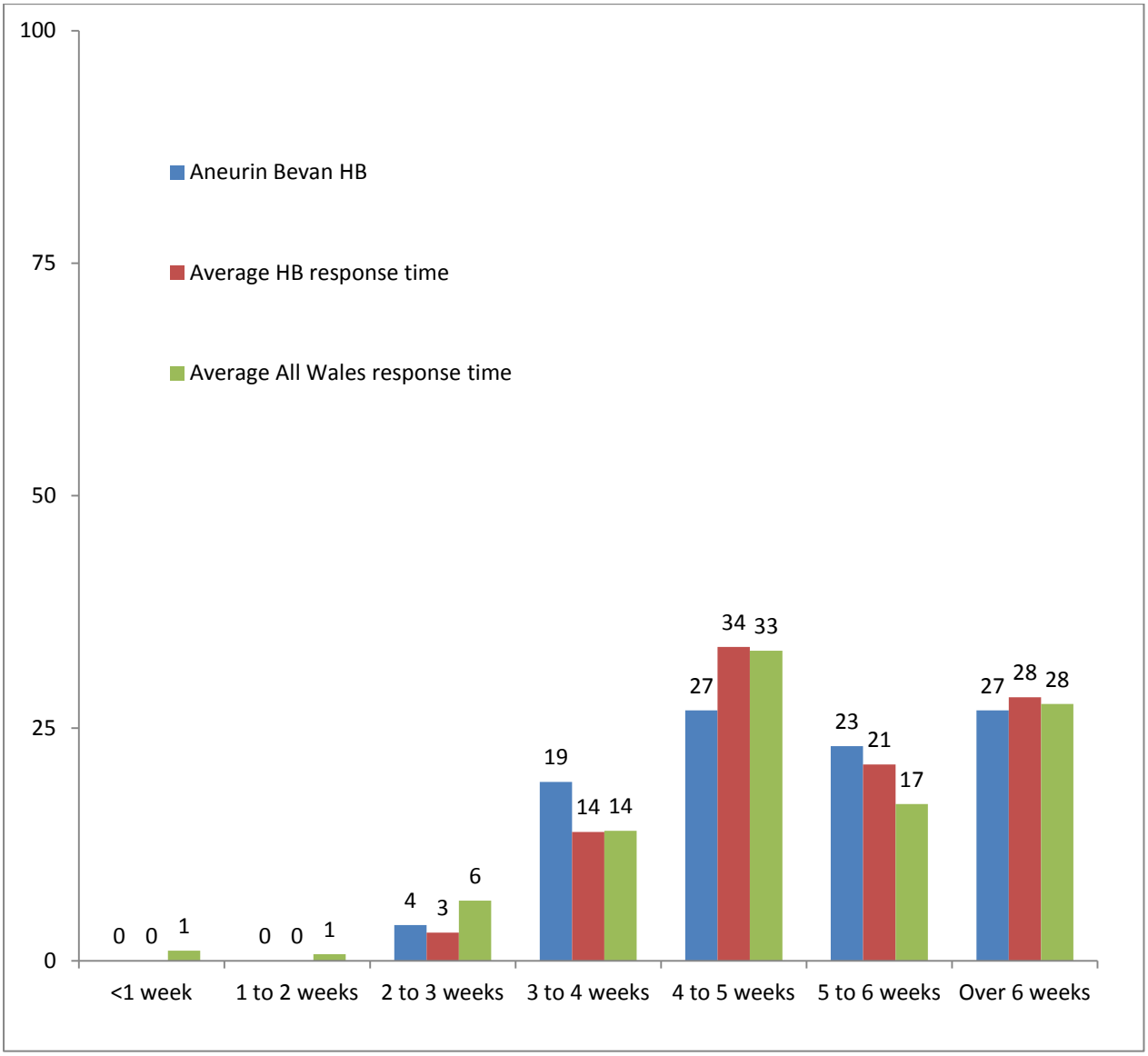
2012-2013



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

Health

Public Interest Reports

December 2012 – Continuing Care – Aneurin Bevan Health Board & Care and Social Services Inspectorate Wales

Ms A complained to me about the treatment and care provided to her mother, Mrs X, whilst she was a resident at "Blue House Care Home". The Care Home had been contracted by Aneurin Bevan Local Health Board ("the LHB") to provide Mrs X's care on its behalf.

Ms A also complained about CSSIW's actions following the investigation of her complaint. In particular its failure to undertake any enforcement action against the Care Home, and its reference to Ms A's complaint as "resolved" in its annual inspection report, a comment Ms A felt was misleading.

Having reviewed all of the information available I found that Mrs X, a patient of the LHB, expected to be provided with a package of NHS care that met all of her needs in a manner that would promote wellbeing, independence, autonomy and self-worth. However the evidence available to me suggested that the care provided by the Care Home on behalf of the LHB failed to meet that expectation.

The LHB contracted with the Care Home that it would undertake a form of contract monitoring, which resulted in a reported annual inspection. In my view the monitoring undertaken at the Care Home was ineffective, and the provisions within the contract relating to complaints handling failed to meet the requirements of the NHS Guide to Handling Complaints in Wales 2003. Ms A's complaint about the LHB was upheld.

With respect to Ms A's complaints about CSSIW, I found that the investigation process had been so narrow that serious failings had not been identified. I also found that the CSSIW compliance process was not robust enough in this case to ensure that service user's basic needs were being adequately met. Furthermore, despite CSSIW recognising that at the time of the investigation and publication of the investigation report, Ms A had not been satisfied with the findings and intended to pursue the matter further, it used the term "resolved" when describing her complaint, this was disingenuous. I partly upheld this part of the Complaint.

The Ombudsman recommended that the LHB and CSSIW pay Ms A £500 and £250 respectively as an acknowledgement of the service failure identified in this report. He also made a number of systemic recommendations including a review of policies and procedures for contracted out care.

Case reference 201100737 & 201103665

Other reports – Upheld

February 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board
Ms J complained about care and treatment for cholecystitis (inflammation of the gallbladder), including the conduct of surgery in December 2011 at Ystrad Fawr Hospital, and a delay in transferring her from Ystrad Fawr to Nevill Hall Hospital. She experienced a bile leak following surgery and needed further surgery to correct that at Nevill Hall hospital. Ystrad Fawr is a local general hospital with day case and short stay surgery; Nevill Hall is a district general hospital. Both hospitals are managed by Aneurin Bevan Health Board.

Regarding the care and treatment for cholecystitis, the Ombudsman found that some form of further investigation was indicated prior to the operation. Further investigation may have identified stones in the bile duct which would have affected the course of Ms J's treatment, and possibly have ultimately avoided the post-operative bile leak. The Ombudsman upheld this part of the complaint although concluded that otherwise the conduct of the surgery was appropriate.

Regarding the timing of Ms J's transfer to Nevill Hall hospital from Ystrad Fawr, the Ombudsman concluded that Ms J could have been transferred sooner. Ms J suffered significant levels of pain soon after surgery and thereafter, although a bile leak was not recorded in the clinical records until a day later.

The Health Board agreed to act on the Ombudsman recommendations to apologise to Ms J, to pay her £1000 to recognise the additional pain and distress she experienced, and to refer this report to the clinicians involved in her care for them to consider.
Case reference 201201205

January 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mrs J complained about a number of issues relating to the care provided to her late mother, Mrs G, at Royal Gwent Hospital and about the Health Board's complaint handling. Because of an obstructed left kidney, Mrs G had a nephrostomy (kidney drainage) tube inserted followed by a stent placed in her ureter (a tube that conveys urine from the kidney to the bladder). Mrs G had found the stenting procedure extremely painful.

The investigation found that the care provided to Mrs G had mostly been of a reasonable standard and most aspects of the complaint were therefore not upheld. However, Mrs G had not been properly prepared for the stenting procedure, so that when she did experience pain she could not safely be administered pain relief and/or sedation. The monitoring of pain was also found to have been inadequate during the procedure. This aspect of the complaint was upheld. There had also been shortcomings in the Health Board's complaint handling but these had been addressed.

It was recommended that the Health Board apologise to Mrs J for failing to properly manage and monitor Mrs G's pain, and that it undertook a review of its pain monitoring documentation and record-keeping for procedures of this kind. The Health Board agreed to implement the recommendations.

Case reference 201102825

January 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mrs B complained about the care her late mother, Mrs P had received while in the care of the Aneurin Bevan Health Board at Nevill Hall Hospital in February 2010. Mrs P was admitted following an outpatient appointment and tests showed that she had cancer of the colon. It was discovered during surgery that cancer had already spread to the abdominal wall and therefore a bypass procedure was performed as a palliative measure.

Initially, Mrs P began to recover from the surgery and it was intended that she be transferred for rehabilitation, with a view to discharge home with appropriate support. Her cancer was terminal but there was some expectation of her life continuing for a period of time. After initially recovering from surgery, Mrs P's condition deteriorated and it was thought she may have had a pulmonary embolism. This was presumed to be the cause of her death. There was no post mortem.
Mrs B did not understand fully the cause of her mother's death and was not satisfied with the responses of the Board. She was also concerned that the family had not been summoned in time to be present when Mrs P died, even though there were signs of her deterioration beforehand.
The Ombudsman's clinical advisers said that the decision to operate on Mrs P had been reasonable and that nursing care had been in line with expectations for post operative surgery. The Board accepted the criticisms made in the report with regard to management of end of life issues and communication with the family. It agreed to implement the recommendations made in the report.
Case reference 201102578

November 2012 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mrs D complained about the care and treatment provided to her mother, Mrs J, during her hospital admission. Mrs J had attended at the A&E Department at a hospital within the local area of Aneurin Bevan Health Board and was admitted due to a broken hip. Sadly she died two days after an operation. Mrs D said that the clinical staff failed to monitor her mother's condition correctly during the post-operative period and/or to take further action when her condition deteriorated.

The Ombudsman found that overall, the management of Mrs J post-operatively was reasonable and that nothing further should have been done that would have changed the eventual sad outcome. However, the Ombudsman found that the Health Board should have provided Mrs D with a clearer explanation of the link between her mother's hip operation and the established cause of death. The Ombudsman recommended that the Health Board should provide an apology to Mrs D for this shortcoming.
Case reference 201103350

November 2012 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mrs B complained about the standard of nursing care provided to her late mother, Mrs S, at Royal Gwent Hospital, Newport in January 2011. Mrs B was also concerned about Aneurin Bevan Health Board's response to her complaint.
The Ombudsman found that overall the standard of nursing care was broadly reasonable, but there were some failings in relation to Mrs S being sat out of bed in

the cold on one occasion, not being put back in bed when this was requested, and around certain aspects of communication with Mrs B. The Ombudsman partly upheld this aspect of the complaint.

The Ombudsman also partly upheld the complaint about the way the Health Board dealt with Mrs B's complaint. Although its initial response was provided within a reasonable timescale, the Health Board's response to Mrs B's second letter of complaint took too long.

The Ombudsman recommended that the Health Board should provide Mrs B with a further formal apology for the failings identified. He also made two further recommendations aimed at improving practice on the ward. The Health Board agreed to implement the recommendations.

Case reference 201200560

October 2012 – Clinical treatment in hospital – Aneurin Bevan Health Board

Ms D complained about the care and treatment provided to her daughter, Ms H, during her multiple admissions at Nevill Hall Hospital (the hospital) between December 2010 and March 2011. Ms D complained that despite her daughter's numerous admissions, the hospital failed to diagnose the cause of her symptoms. Ms D said that following Ms H's final discharge from the hospital, she was admitted to another local hospital in the area. Ms D said that within a few days of her admission, a diagnosis of Addison's disease (a rare disorder of the adrenal glands, also known as primary adrenal insufficiency) was made. Ms D complained that as a result of the hospital's failure to diagnosis her daughter's condition at an earlier stage, she will suffer with the disease for the rest of her life. She also complained about the number of different medications prescribed to her daughter while under the hospital's care.

The Ombudsman found that although the hospital failed to reach a diagnosis of Ms H's condition during her admissions, in general, the care and treatment provided to her was appropriate. Ultimately, the Ombudsman concluded that diagnosis of adrenal insufficiency is difficult to make, given the rarity of the condition and the general nature of the presenting symptoms, and it was not possible to confirm what, if any, the effect of the time taken to make the diagnosis had on Ms H's future condition. However, the Ombudsman found that the clinicians had failed to appreciate the deterioration in her condition and the appearance of new symptoms during her admissions. The Ombudsman found that the clinicians failed to carry out a review of Ms H's medication, in accordance with good medical practice, and that there was no evidence that the Health Board had reflected upon this case or had put measures in place to assist the clinicians to make a diagnosis in similar future cases.

The Ombudsman recommended that the Health Board should consider the failings identified and provide confirmation of the further action taken to address the inadequacies in the hospital's procedures to review existing and new symptoms, to review a patient's medication and to ensure that difficult cases such as Ms H's are reflected upon to prevent a recurrence of similar failings in the future. The Ombudsman also recommended that the Health Board provide an apology to the family, in particular, for its failure to recognise that Ms H had many of the symptoms of adrenal insufficiency during her admissions to the hospital.

Case reference 201101687

October 2012 – Clinical treatment outside hospital – Aneurin Bevan Health Board
Mrs M complained about the standard of care and treatment provided to her late mother-in-law, Mrs P, by an out-of-hours GP. Mrs P had chronic obstructive pulmonary disease and had become unwell over the previous few days.

The Ombudsman found that the assessment carried out by the out-of-hours GP fell below a reasonable standard as he failed to measure, or record, Mrs P's blood pressure, respiratory rate and oxygen saturation. The symptoms Mrs P was complaining of, together with her abnormal pulse, should have prompted a more detailed and thorough assessment, which may have led to her being admitted to hospital sooner than she was. That said, the Ombudsman concluded that as Mrs P was admitted to hospital around three hours later, it was unlikely that this would have affected Mrs P's chances of survival.

The Ombudsman upheld the complaint to the extent that the three hour delay before Mrs P was admitted to hospital would have added to her and her family's anxiety and distress. The Ombudsman recommended that the Health Board apologise to Mrs M for the failings identified and remind the out-of-hours GP of the need to carry out a full assessment of patients when their symptoms suggest that further investigations are required. The Health Board agreed to carry out the recommendations.
Case reference 201200215

July 2012 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mrs A underwent a surgical procedure known as an Antegrad Continence Enema ("ACE") in 2001 to relieve chronic constipation. Following this she needed to use an enema preparation to empty her bowel on a regular basis. Between 2001 and 2010 Mrs A was admitted to hospital several times; her clinical records show that she reported on more than one occasion that she had fainted after using the ACE. In September 2010 she was again admitted to hospital complaining of nausea, headache, facial numbness and muscle spasms. She was found to have raised levels of phosphate and reduced calcium levels in her blood, which were attributed to her use of the enema, and the preparation Mrs A was using was changed.

The Ombudsman found that many of the symptoms Mrs A reported over the years were recognised side effects of the enema preparation, and that her episodes of collapse were likely to have been related to its use. There were three occasions when the Consultant questioned its long-term use, but no action was taken in respect of this; the Ombudsman considered that the failure to pursue other options was a serious failing. He also found that Mrs A had been given inadequate information and advice about the use of the product, and was critical of some aspects of the LHB's record-keeping. He recommended that the LHB should apologise to Mrs A, review the long-term use of this and similar preparations, and review its record-keeping system. The LHB agreed to implement the recommendations.
Case reference 201101811

July 2012 – Clinical treatment in hospital – Aneurin Bevan Health Board & Cardiff and Vale University Health Board

The complaint was made by Mrs X against Cardiff and Vale University Health Board and Aneurin Bevan Health Board and concerned the delay in the clinical pathway that led to Mrs Y's surgery for lung cancer. Mrs X also expressed concern that Mrs Y's family had not been advised by the Health Boards about the nature and severity of Mrs Y's lung cancer. She also complained that the cause of Mrs Y's death remained unclear and referred to incorrect information having been provided by Aneurin Bevan Health Board.

Mrs X made a related specific complaint about the care and treatment that Mrs Y received following her admission on 11 February 2010 to the Royal Gwent Hospital.

The Ombudsman upheld the complaint that in Mrs Y's case the clinical pathway was too long and did not comply with the Welsh Government target standard. Both Health Boards were responsible for this delay. Although this was a the significant failing, the Ombudsman concluded that it was probably not relevant to the subsequent deterioration in Mrs Y's health, although the delay left some unanswered questions for the family and added to their distress.

There was evidence that discussion did take place with Mrs Y about her cancer in September 2009 but it was impossible to identify the exact detail of the conversations that took place. It also could not be confirmed from the records who attended appointments with Mrs Y or how the family should have been involved. A clear judgement could not be made on this element of the complaint.

Taking account of the view of the Medical Advicer it was clear that it was impossible to know the exact cause of Mrs Y's death and it was noted that the Health Boards did not attempt to provide a coherent and joined up response to Mrs X and family. Aneurin Bevan Health Board also added to the family's lack of clarity about Mrs Y's death by referring to another clinical condition as a cause of death. The Ombudsman upheld that element of the complaint accordingly.

The complaints about the inpatient care and treatment in relation to Mrs Y's admission to hospital in February 2010 were not upheld. Mrs X also complained about Mrs Y's discharge arrangements and the Ombudsman found that there were a number of significant shortcomings in the discharge planning and the Ombudsman upheld this element.

It was recommended that both Health Boards apologise to Mrs X for the delay in the clinical pathway leading up to Mrs Y's surgery and provide a combined redress payment of £1,500 to Mrs X and family for the time and trouble in making the complaint and in recognition of the added distress caused by the delay. Both Health Boards were also recommended to review their procedures. A separate recommendation was made to Aneurin Bevan Health Board to ensure that ward staff undertook training in discharge planning.

Case reference 201101059 & 201101060

July 2012 – Clinical treatment in hospital – Aneurin Bevan Health Board

Mrs A and Miss A complained about their late mother, Mrs B's, treatment and care whilst she was an inpatient at Nevill Hall Hospital in December 2010, when she sadly passed away. Mrs A and Miss A were unhappy about many aspects of Mrs B's

medical and nursing care. The fundamental issues related to whether there were unreasonable delays in initiating appropriate treatment and care that contributed to Mrs B's decline.

After taking advice from a Consultant Geriatrician and experienced Senior Nurse, the Ombudsman found that Mrs B's frailty during her final hospital admission was attributable to factors associated with her underlying medical conditions and was not as a consequence of any significant failings in the treatment and care provided by the Health Board. However, the assessment and management of Mrs B's pain lacked a formal or systematic approach and her initial pain management did not reflect the standard of care that could reasonably be expected. There were also shortcomings in the Health Board's handling of Mrs A and Miss A's complaints.

The Ombudsman asked the Health Board to provide evidence that it had adequate arrangements in place for systematic pain monitoring and recording and to share the learning from the findings of the investigation with the relevant nursing staff and its complaint handlers. The Health Board also agreed to apologise to Mrs A and Miss A and to make a payment of £150 each for the failings identified.

Case reference 201100644

July 2012 – Clinical treatment in hospital – Aneurin Bevan Health Board

Mrs B complained about the treatment of her mother, Mrs K, during a hospital admission. Mrs K sadly died in November 2008. Mrs B complained about the pain relief prescribed to her mother, both in terms of the choice of morphine and in respect of the dosage. She complained that morphine was given despite her mother having an aversion to it and despite her having a compromised respiratory system. Mrs B said that Mrs K was given an overdose of morphine which prematurely ended her life. Mrs B complained that her mother had been "euthanised" and that her medical records had been subsequently tampered with to cover this up.

The Ombudsman found that the use of morphine was clinically appropriate, although communication with Mrs B and Mrs K over its use was lacking. The Ombudsman found that although there was a clear drug error in the dosage recorded as having been given to Mrs K and that this error had not been appropriately investigated at the time, the erroneous dosage was not sufficient to have caused death and there was no evidence to suggest that it had done so. The Ombudsman found that although there had been errors in the administration of Mrs K's full medical records (which remain lost) there was no evidence to suggest that the records had been tampered with in order to cover anything up.

The Ombudsman recommended that the Health Board should apologise to Mrs B for the failings identified, should take practical action to address both the drug error and the failure to investigate it properly and should make amendments to its record-keeping policy.

Case reference 201100744

June 2012 – Continuing care – Aneurin Bevan Health Board & Caerphilly County Borough Council

Mr F cared for his wife, Mrs F, at home with assistance on a daily basis from carers provided and funded by the Council. Mrs F had alzheimer's disease. An application

was made for continuing health care (CHC) funding for Mrs F because the Council considered that her needs had increased. No decision on eligibility was made for over a year by the Health Board until just prior to Mrs F's death. The Ombudsman found that there were shortcomings in the Health Board's systems that resulted in its failure to reach a decision on Mrs F's eligibility. This failure and the delays overall in this case were unacceptable. There was also a lack of clarity about the need for night care for Mrs F and/or a night sitting service to Mr F as a carer.

The Ombudsman recommended that the Health Board apologise to Mr F for the identified failings and that it should ensure that improvements were made to its systems for considering all CHC eligibility applications.
Case reference 201001820 & 201002050

May 2012 – Appointments/admissions/discharge & transfer procedures – Aneurin Bevan Health Board
Mr A complained that there was a delay in reinstating his father (Mr B) on an orthopaedic surgery waiting list after being passed fit for surgery by a Cardiologist; that his father may not have been reinstated in the correct place in the list; that there were problems in obtaining information from the Health Board about his father's position on the list; and that requests for information about the options for his father being treated in a different health board area were not responded to.

The Ombudsman found that due to a communication error, there was some avoidable delay (of about seven weeks) in reinstating Mr B on the waiting list. He upheld the part of the complaint about the management of the waiting list to that extent only. The Ombudsman upheld the complaint about the difficulties Mr B encountered trying to obtain information about his position on the list. The problems had already been acknowledged by the Health Board and action was being taken to address them. The Ombudsman also upheld Mr A's complaint that the Health Board did not respond to his request for information about treatment options elsewhere. The Health Board accepted that the information had not been provided as it had assumed that as Mr B had already agreed a date for surgery at that point, he no longer wanted it.

The Ombudsman recommended that the Health Board should apologise to Mr B for the failings identified and carry out an audit to establish if the measures it had already taken to improve patients' ability to contact the waiting list office had made things better. The Health Board agreed to implement the recommendations.
Case reference 201102360

May 2012 – Appointments/admissions/discharge & transfer procedures – Aneurin Bevan Health Board, Cwm Taf Health Board & Caerphilly County Borough Council
Mrs C complained about aspects of the care and treatment of her severely disabled husband following his admission to Prince Charles Hospital (PCH) in February 2009. PCH is managed by Cwm Taf Health Board. Mr C was transferred to Ystrad Mynach Hospital (YMH) from where he was discharged home in June 2009. YMH is managed by Aneurin Bevan Health Board. Caerphilly Council's social services were also involved in Mr C's care.

The Ombudsman's investigation found that as Mr C's ability to communicate was very limited, his capacity should have been assessed under the Mental Capacity Act 2005 (MCA). Despite Cwm Taf HB and Caerphilly social services being in agreement with the need for this, Cwm Taf HB failed to carry out an assessment. This meant that, at best, Mr C was given very little choice about his care and treatment, and about whether he remained in hospital, and, at worst, he was detained in hospital against his will. This was therefore a significant failing and the complaint was upheld. Cwm Taf and Aneurin Bevan Health Boards agreed with the Ombudsman's recommendation to provide training to staff about their responsibilities under the MCA.

The Ombudsman investigated a number of other complaints. He concluded that it had taken too long to discharge Mr C from hospital, and asked the authorities to consider how the process can be speeded up. He also upheld a complaint that Mr C was allowed to remain constipated for several days. But he did not uphold complaints relating to mouth care and provision of antibiotics, or that it was inappropriate to consider the possible need to instigate the Protection of Vulnerable Adults procedure.

Finally, the Ombudsman upheld Mrs C's complaint that the three bodies failed to provide a joint or cohesive response to her complaints.
Case reference 201002841, 201100156 & 201100157

May 2012 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mrs W complained to the Ombudsman about the care provided to Miss B whilst a patient at Nevill Hall and Tredegar General Hospitals. Mr and Mrs W were carers for Miss B, who had Down's syndrome. Mrs W considered that the hospitals failed to treat Miss B with appropriate antibiotics and failed to diagnose a urinary tract infection. They also considered that staff failed to take appropriate account of Miss B's learning disabilities when considering her needs; failed to assist her to regain her mobility and; failed to provide appropriate support cushions. Mrs W also considered that instead of transferring Miss B from Nevill Hall Hospital to Tredegar General Hospital they should have discharged her home. Sadly Miss B died in Tredegar Hospital from a complication following an infection.

The Ombudsman found that the medical care provided to Miss B had been reasonable although he considered that there was a possible shortcoming in the measures taken to diagnose Miss B's final infection. However he did find a number of failings in the overall care provided to Miss B, which in the main stemmed from a failure to take proper account of, and make adjustments to, Miss B's requirements because of her special needs. The Ombudsman upheld a number of aspects of Mrs W's complaint in relation to the care provided to Miss B and made a number of recommendations relating to changes the Health Board should implement in order to ensure that patients with learning disabilities are given care which is properly adjusted to meet their needs. The Health Board agreed to implement the recommendations.
Case reference 201100407

Other reports – Not Upheld

February 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mrs W complained about the treatment her late husband received at one of Aneurin Bevan Health Board's hospitals. In 2007, Mr W underwent a CT bowel scan, having been treated for a cancerous rectal polyp almost two years previously. He suffered a cardiac arrest in the scanner. He was resuscitated but sadly died of heart failure two years later. Mrs W's complaints were that:

• the CT bowel scan was not clinically necessary;
• they were not given adequate information about the procedure, the preparation for it or the possible risks in order to give informed consent; and
• the Colorectal Surgeon did not provide the radiology department with sufficient information about Mr W's medical history to allow its staff to evaluate whether he was fit for the procedure.

While appreciating that Mr W's cardiac arrest in the CT scanner must have been a very frightening experience for him and for Mrs W, the Ombudsman concluded that the CT scan was necessary. The risk of Mr W having a further cancer far outweighed the risk of the CT scan.
Mr W was broadly aware of what the CT scan would involve and the reason for undergoing it. While Mr W could have been given more detailed information about the procedure, the Ombudsman concluded that the cardiac arrest could not have been foreseen and that the Colorectal Surgeon could not reasonably have been expected to warn Mr W of this as a possible complication.

The Colorectal Surgeon did not include details of Mr W's history of heart attack several years previously on the radiology request form. An independent clinician had concluded that the information should have been included. However, the Ombudsman found that the decision to carry out the procedure would not have been different if the radiology department had been informed of Mr W's medical history. The complaints were not upheld.
Case reference 201103200

October 2012 – Clinical treatment in hospital – Aneurin Bevan Health Board
Miss T complained about Aneurin Bevan Health Board in relation to care of her late mother, Mrs T, in 2009 and 2010. She said that Mrs T was discharged from its hospitals on four occasions when she was too poorly and required further medical care. Miss T also complained that during a stay in hospital during late 2009 and early 2010, care relating to treatment for serious infections, was inadequate.
The Ombudsman found that Mrs T was fit for discharge on each of the four occasions under consideration, although she was poorly. He did not find any reason to criticise Mrs T's care whilst in hospital over the 2009/2010 period. The Ombudsman did not uphold Mrs T's complaints.
Case reference 201103367

Quick fixes and Voluntary Settlements

October 2012 – Clinical treatment in hospital – Aneurin Bevan Health Board
The complainant complained that the Health Board has repeatedly failed to recognise her as her partner's Next of Kin during the times her partner was admitted to hospital for treatment for her mental health. The complaint was previously raised with the HB in 2010 and an ICS report was produced.

The ICS report had recommended that the complainant be (or should have been) provided with information about the Mental Capacity Act and how individuals with mental health problems are assessed to determine their capacity to make decisions. The Health Board agreed to consider the complaint as a new complaint, and also to provide her with information about the Mental Capacity Act to inform her of the processes undertaken.
Case reference 201201339

October 2012 – Complaint-handling – Aneurin Bevan Health Board
Mr M complained that Aneurin Bevan Health Board failed to respond to his Solicitors' letters chasing a response to his complaint, regarding the care received by his late mother whilst a patient at the Hospital. He says he should have received a response to his concern within the prescribed time under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

After contact by my office,it was found that the Health Board had not responded to the complaint within the prescribed 30 days from receipt of the date the Health Board received the complaint and, it had also failed to inform Mr M and/or his Solicitors of the reason it could not meet this requirement. The Health Board agreed that the delay and its failure to properly respond or explain the reason for the delay within the thirty day period was unacceptable and it agreed to write to Mr M's Solicitors apologising for the unacceptable delay, to explain the reason for the delay and to explain the current progress of the Health Board's investigation into Mr M's complaint.
Case reference 201202438

August 2012 – Continuing care – Aneurin Bevan Health Board
Mr F complained about the period of time for which his late mother, Mrs F, had been assessed as being eligible for NHS funded continuing care. He complained that Aneurin Bevan Health Board had failed to properly consider his mother's needs and had agreed to fund only part of her care home fees. Mr F further complained that, when his claim for reimbursement was referred to Powys Teaching Health Board, it further reduced the period of time for which his mother was deemed eligible.

Following advice from one of his professional clinical advisers, the Ombudsman concluded that, whilst the Powys Teaching LHB's consideration of eligibility was not robustly supported by evidence, Aneurin Bevan LHB's was supported. The Ombudsman therefore asked Aneurin Bevan to settle the claim on the basis of the period that it had previously assessed Mrs F as being eligible. The Health Board agreed to this voluntary settlement and the Ombudsman therefore discontinued his investigation.
Case reference 201102171