Our ref: MG/jm

Your ref:

Date: 15 July 2014

Ask for: James Merrifield

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Dr Andrew Goodall
Chief Executive
Aneurin Bevan University Health Board
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Dear Dr Goodall

Annual Letter 2013/14

Following the recent publication of my Annual Report, I am pleased to provide you with the Annual Letter (2013/14) for Aneurin Bevan University Health Board.

As set out in the Annual Report, the past year has seen a continuation of the upward trend in enquiries and complaints received by my office. Health complaints are again the most numerous type of complaint, with such complaints now having increased by 146% over the past five years. Whilst there are likely to be a number of reasons for such an increase, it has to be concluded that it is also an indication that increasingly health service delivery, and furthermore health complaint handling, is not what it should be.

In reference to the overall performance of health boards in Wales, my office has issued more reports in which the complaint was upheld, and fewer reports in which the complaint was not upheld, compared with 2012/13. The figures show that the largest number of health complaints again relate to clinical treatment in hospital, whilst there have also been noticeable increases in the numbers of complaints about appointments, admissions, discharges and transfer procedures, as well as continuing care.

I issued nine public interest Reports in 2013/14, the majority of which related to health complaints. These reports identified serious failings in respect of the following:

- acting in accordance with national guidelines for the treatment of stroke;
- making reasonable adjustments to accommodate a patient's deafness;
- the implementation of guidelines designed to prevent misdiagnosis of early pregnancy loss;
- treatment in respect of cirrhosis;
- treatment provided by an Out of Hours GP;
- dealing with a patient's condition on arrival at an Accident and Emergency Department;
- incomplete records, leading to a lack of clarity over whether a patient had received medication for Parkinson's disease; and,
- significant maladministration in two continuing care assessments.

Clearly, these failings are diverse in their nature. I would encourage all health boards to consider the lessons from these cases and the recommendations made; look at your own practices and satisfy yourselves that your own arrangements for service delivery in these areas are appropriate and that your staff are suitably trained.

In considering other outcomes, it is worth noting an increase in the levels of 'Quick Fixes' and 'Voluntary Settlements', in comparison to 2012/13. In view of the increasing level of health complaints, the benefits of resolving certain types of complaints quickly, without the need for a full investigation, should not be underestimated. I am encouraged that health boards are co-operating in achieving these types of resolutions.

In reference to the amount of time taken by public bodies in Wales in responding to requests for information from my office during 2013/14, whilst there has been an increase in the percentage of responses received within four weeks, 36% of responses from public bodies have taken more than 6 weeks. I have outlined my concerns in the Annual Report over the way in which complaints are handled, and have also previously referred to 'delay', and the consequences of it, in The Ombudsman's Casebook. Clearly, there remains work to do to ensure that public bodies are providing information promptly and I urge all bodies to consider whether their performance in this area warrants further examination.

In reference to your Health Board, there has been a slight increase in the number of complaints received and investigated, compared with 2012/13. The largest single area of complaint remains 'clinical treatment in hospital', which is above the health body average. There have also been noticeable increases in the numbers of complaints relating to 'appointments, admissions, discharges and transfer procedures' and 'compliant-handling'. My office has had cause to issue one Public Interest Report against your Health Board. In view of the comparatively low numbers of quick fixes and voluntary settlements achieved in relation to your Health Board, I would ask you to ensure that your Health Board staff are aware of the benefits of such methods of complaint resolution by familiarising themselves with the enclosed summaries. Finally, in reference to your Health Board's response times, more than half of responses took more than five weeks.

I have copied this correspondence to the Chair of your Health Board with the intention that it be considered by the Board. The new Ombudsman will be taking up his post in August and I am sure he will be in touch at an appropriate time to introduce himself and to discuss some of the above matters. Finally, following the practice of previous years, a copy of the annual letters issued to health boards will be published on the PSOW's website.

Yours sincerely

Professor Margaret Griffiths
Acting Ombudsman

Copy: Chair, Aneurin Bevan University Health Board

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received by my office in 2013/14 with the average for health bodies (adjusted for population distribution) 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 2013/14, 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 2013/14.

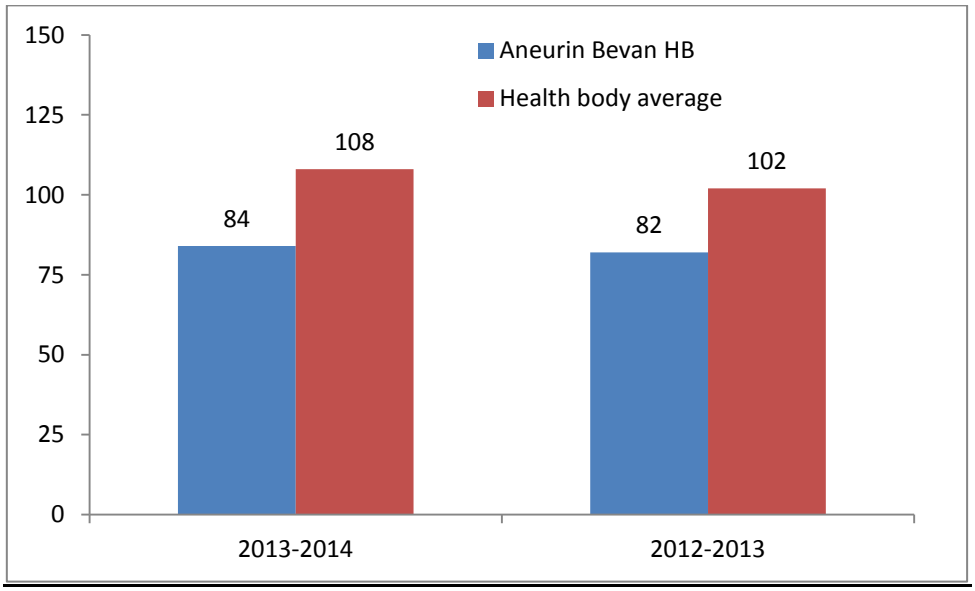
Section E compares the number of complaints against the Health Board which were taken into investigation by my office in 2013/14, with the average for health bodies (adjusted for population distribution) during the same period.

Section F compares the complaint outcomes for the Health Board during 2013/14, 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 2013/14, 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 2013/14.

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

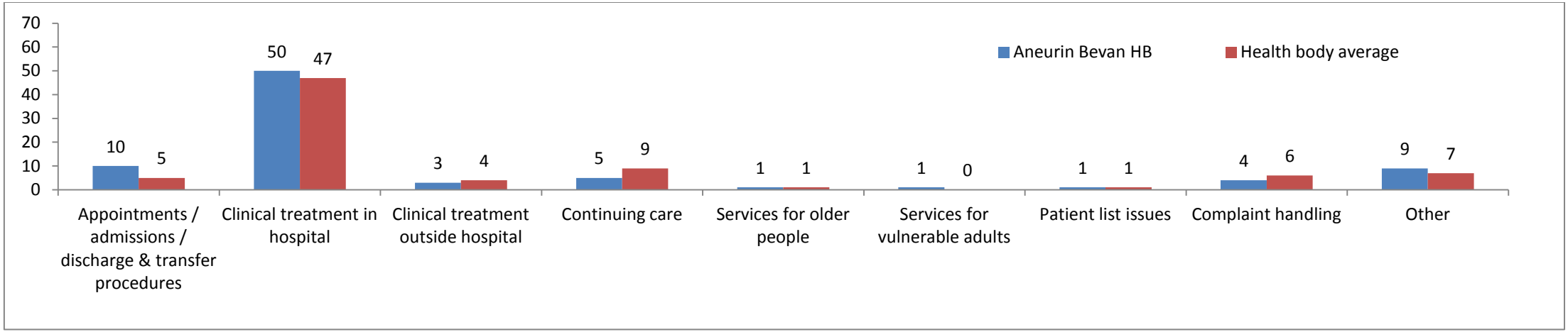


B: Complaints received by my office

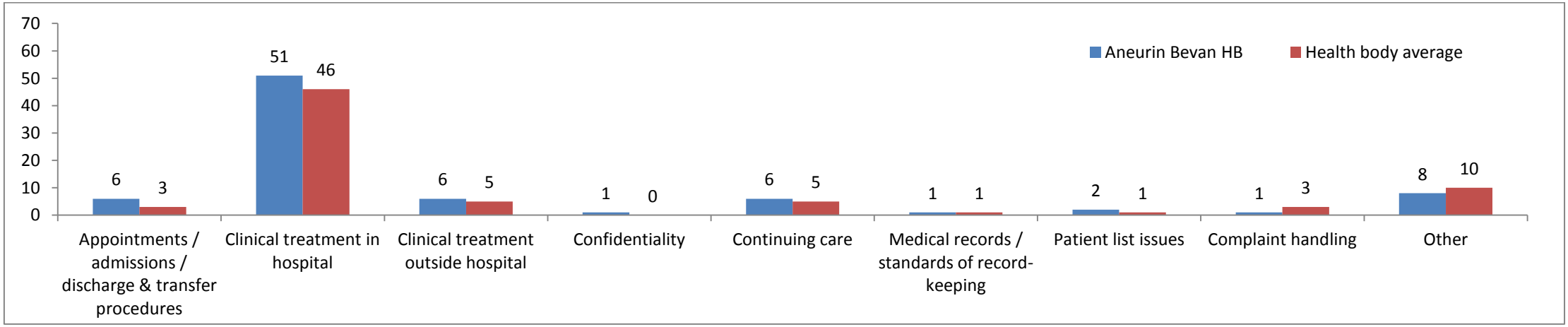
Subject	2013/14	2012/13
Appointments/ Admissions/ Discharge and transfer procedures	10	6
Clinical treatment in hospital	50	51
Clinical treatment outside hospital	3	6
Confidentiality	0	1
Continuing care	5	6
Medical records/ standards of record-keeping	0	1
Services for older people	1	0
Services for vulnerable adults	1	0
Patient list issues	1	2
Complaint-handling	4	1
Other	9	8
TOTAL	**84**	**82**

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

2013/14



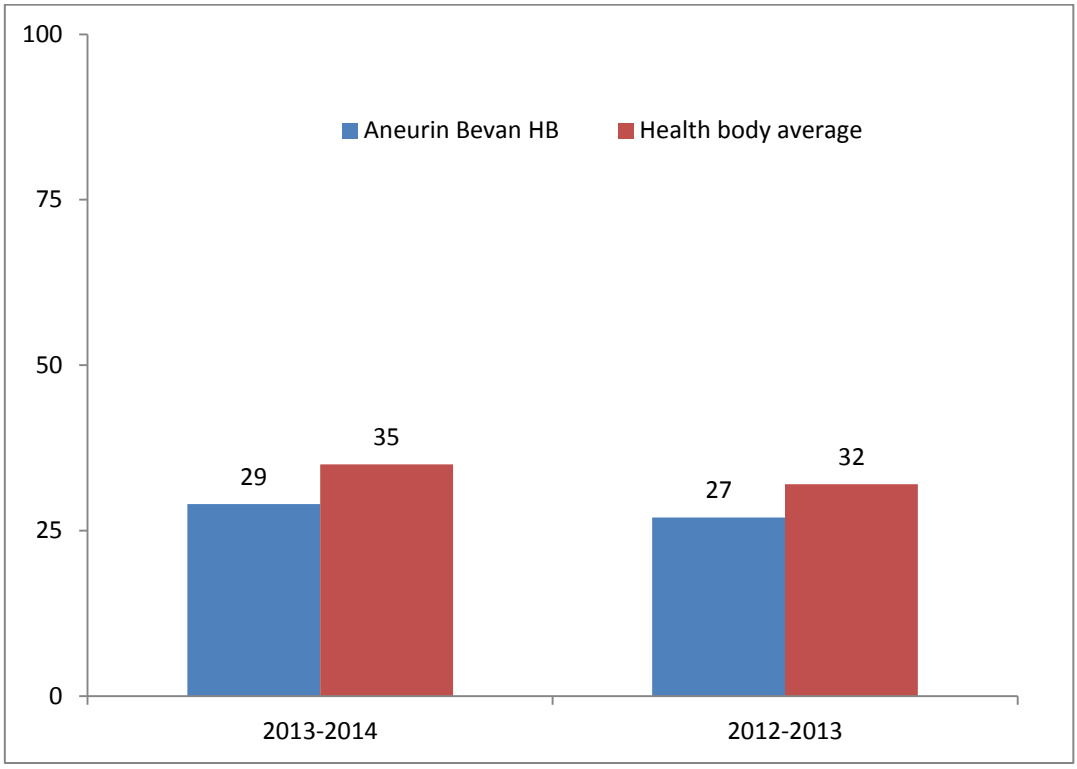
2012/13



D: Complaints taken into investigation by my office

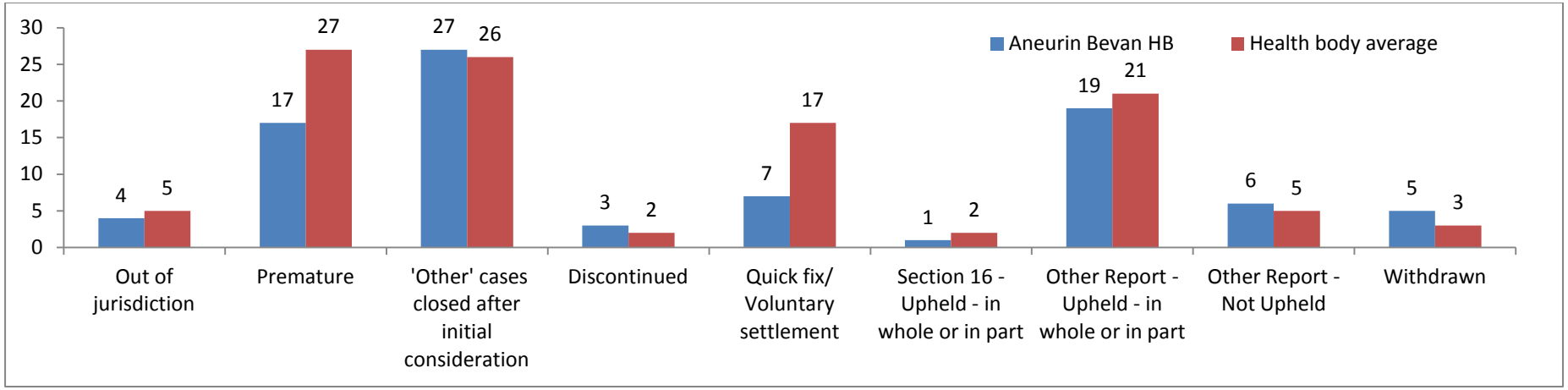
	2013/14	2012/13
Number of complaints taken into investigation	29	27

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

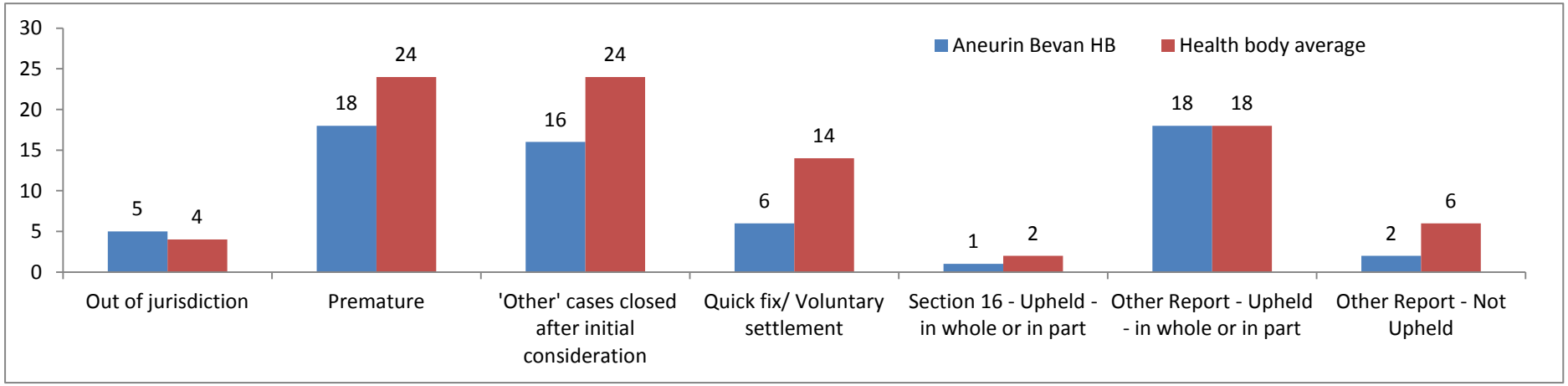


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

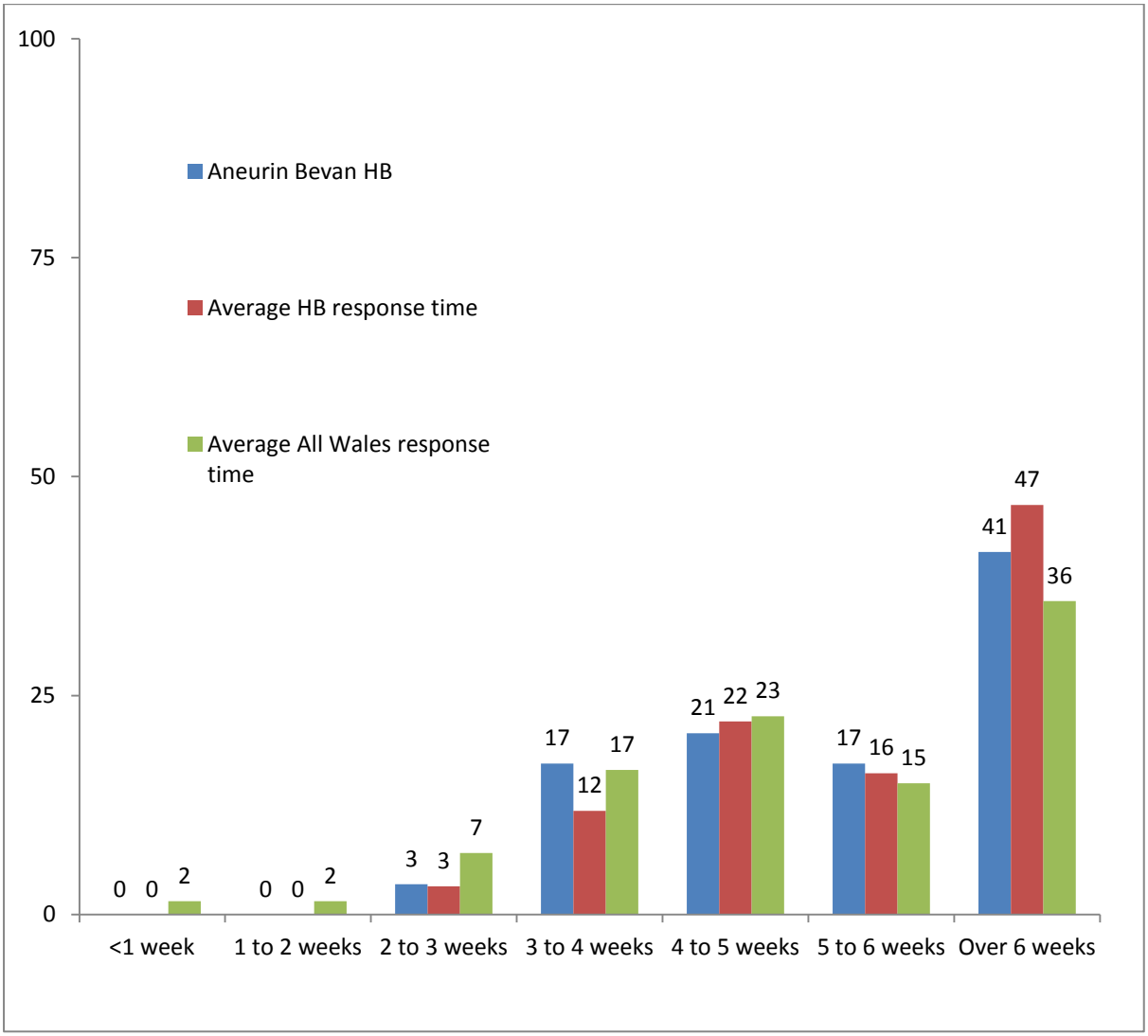
2013/14



2012/13



G: Comparison of Health Board times for responding to requests for information with average for health bodies and All Wales response times, 2013/14 (%)



H: Summaries

Public Interest Reports

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201204681 – Report issued December 2013
Mrs W complained about the care provided by Aneurin Bevan Health Board ("the Health Board") to her late husband ("Mr W") when he was a patient at Nevill Hall Hospital ("the Hospital") in September and October 2011. Mr W was 80 years old when he died in hospital on 7 October 2011.

Mrs W said that Mr W was deaf, but despite advising staff of this, it was not noted on his records. Mrs W said she believed that her husband was not treated in his best interests and that his care was compromised because staff did not consider his deafness. Mrs W said that she and her husband were not told about a cancer diagnosis by the Hospital. She also said that she was dissatisfied with the way that the Health Board communicated with her and her family both during the time Mr W was a patient and when the Health Board was considering the complaint she made about his care.

The investigation found that, as required by the Equality Act 2010, the Health Board failed to make reasonable adjustments to accommodate
Mr W's deafness. The investigation also found that the Health Board failed to:

- Record a significant clinical discussion with Mr W about scan results.
- Complete and record appropriate assessments relating to the risk of falling and the use of bed rails.
- Consult Mr W and record his consent for the insertion of a catheter.
- Follow national and local guidance on effective discharge planning.
- Keep appropriate records related to the discharge process.
- Follow relevant guidance on record-keeping.

The Ombudsman upheld the complaint and the Health Board agreed to:

a) give Mrs W an unequivocal written apology for failures identified by this report and make a payment of £500 to reflect the time and trouble taken in pursuing her complaint with the Health Board and this office.
b) formally instruct the nursing and clinical staff involved in Mr W's case that they must assess patients properly on admission and ensure that all relevant records of such assessments (for example, the Patient Care Record) are completed fully.
c) formally instruct the nursing and clinical staff involved in Mr W's case to follow the relevant record keeping guidance.
d) formally instruct the clinical staff involved in Mr W's case to ensure that significant clinical discussions with patients (such as the results of a scan) are recorded properly.
e) formally instruct the nursing staff involved in Mr W's case to ensure that all appropriate risk assessments are completed and properly recorded.
f) formally instruct the nursing and clinical staff involved in Mr W's case to follow the relevant discharge planning guidance.

g) share this report with all staff involved in Mr W's care so that the lessons that should be learned from the report can be understood.
h) ensure that this report is discussed at a meeting of each Directorate that cared for Mr W so that the lessons of the report are disseminated.
i) ensure that this report is discussed at a meeting of the working group responsible for the Health Board's "Dignified Care?" action plan.

Other reports - Upheld

Aneurin Bevan Health Board – Appointments/admissions/discharge/transfer procedures
Case reference 201300049 – Report issued March 2014
Mr L complained to the Ombudsman about Aneurin Bevan Health Board ("the Health Board"). He said that his wife, Mrs L, was diagnosed with severe aortic stenosis and that she had been waiting more than a year for cardiac surgery. Mr L said he had complained to the Health Board about the delay and he was dissatisfied with the Health Board's response to his complaint.

The Ombudsman's investigation identified avoidable administrative delays in the Health Board's management of Mrs L's care along with several missed opportunities to take action to deal with those delays. The investigation also concluded that the Health Board's own investigation of the complaint should have identified, and apologised to Mrs L for, the failings this investigation found.

Following this investigation, the Health Board apologised for the failure to list Mrs L for an echocardiogram in March 2012. It acknowledged that there had been administrative delays and that the delay in a referral to a Specialist Hospital was unacceptable. The Health Board also apologised that a later "expedite" letter had not been sent. It said that it was in the process of implementing electronic referral and digital dictation systems which would address some of the issues identified by the investigation.

The Health Board also apologised for the confusion caused by its incorrect statement that it was not Government policy to offer long waiting patients treatment at an alternative hospital. It said that, since January 2014, it had been transferring the care of a small number of patients to England for cardiac surgery and that it intended to extend these arrangements.

The Health Board accepted the report and agreed to:

- give Mr and Mrs L a written apology for the failings indentified by this report;
- pay Mrs L £750 in redress in recognition of the anxiety and distress caused by the avoidable delays
- formally remind the Cardiology Directorate of the Annual Leave Policy;
- formally instruct Cardiology Directorate clinicians of the requirement to ensure that onward referrals to other services, including tertiary care and the Specialist Hospital are dealt with promptly (in line with the Waiting Time Guidance);
- complete an independent audit of first 100 inbound referrals received by the Cardiology Directorate (excluding those to a named cardiologist) since 1 February 2014. The audit should identify whether there has been any similar failing to arrange necessary diagnostics (e.g. echocardiography). If indicated by the outcome of the audit, the process used by the Cardiology Directorate for dealing with inbound referrals should be revised and all relevant staff should be informed of the revised process;
- complete an independent audit of the first 50 onward referrals made by the Cardiology Directorate to other departments/ hospitals since 1 February

2014. The audit should identify the routine time taken between the decision to make a referral and the referral being sent. If the audit identifies unreasonable delays, the process used by the Cardiology Directorate for making onward referrals should be revised and all relevant staff should be informed of the revised process;
- discuss the Ombudsman's report and the results of both audits at the next meeting of the Cardiology Directorate's management team;
- provide evidence to this office that all the above recommendations have been completed.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201301644 – Report issued March 2014
Mr G complained that he was discharged from hospital without having been diagnosed with heart failure. He complained that doctors failed to properly diagnose him and also failed to advise him against travelling to New Zealand two days after discharge. He also complained that his ongoing warfarin therapy was not appropriately organised. Mr G complained that he was therefore unable to enjoy his holiday and also had to pay for private medical treatment in New Zealand.

The Ombudsman found that Mr G had not been properly diagnosed and should have been robustly warned against travelling. The Ombudsman also found that doctors had failed to make adequate arrangements to monitor Mr G's warfarin therapy. The Ombudsman concluded that if doctors had properly diagnosed/advised Mr G, he probably would not have travelled to New Zealand or incurred medical treatment costs. The Ombudsman made the following recommendations:

a) the Health Board should provide Mr G with a comprehensive written apology for the failings identified;
b) the Health Board should pay Mr G redress in the sum of £700 in respect of the medical costs he incurred in New Zealand, the distress caused by the failings identified and the time and trouble to which he was put in pursuing this complaint;
c) the Health Board should review the failings identified in this report with the clinicians involved in Mr G's care and discuss them as part of their professional development/appraisal process.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201204771 – Report issued February 2014
Ms A complained about the care and treatment provided at the Royal Gwent Hospital from 2006 to 2012. Specifically, Ms A complained about the time taken to diagnose her breast cancer and subsequently to detect her bone metastases disease. Ms A also complained that the Health Board's response to her complaint was delayed and said that the response did not address all of her concerns.

The Ombudsman **partly upheld** the complaint. Having obtained professional advice on the clinical aspects of Ms A's care, the Ombudsman found that Ms A's consultations were carried out in accordance with expected standards. In particular, the time taken to reach a diagnosis of Ms A's breast cancer and the subsequent action taken was reasonable. However, the evidence confirmed that there were

shortcomings in the handling of Ms A's complaint. There was a delay in providing a response to her concerns in accordance with the complaints handling guidance "Putting Things Right".

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201204402 – Report issued January 2014
Mrs A complained that following her father's hip replacement surgery in 2008 he continued to report being in pain during the period 2009 to 2012. Mrs A also complained that during the course of her father's physiotherapy and hydrotherapy sessions his continued reports of persistent pain were not adequately addressed and that there was a delay in referring her father back to the orthopaedic surgical team.

The Ombudsman's investigation found that the medical care that Mrs A's father received was adequate. However the investigation highlighted shortcomings in relation to the physiotherapy care that Mrs A's father received and this aspect of her complaint was **upheld**.

The Ombudsman recommended that the Health Board should:

a) within **one month** of the date of this report write to Mrs A to apologise for the failings identified by the investigation and pay a sum of £250 for the failure to refer Mrs A's father to the Orthopaedic Team which resulted in additional delay to see the Surgeon;
b) remind Consultants of ensuring any referral back to them is clearly documented in the referral letter;
c) provide documentary evidence of action it has taken to remind its staff of the documentation standards and discharge process for patients accessing hydrotherapy.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201202745 – Report issued December 2013
Mrs T complained about the care and treatment that she received at the A&E Department of the Royal Gwent Hospital when she was admitted as an emergency following an intensification of the chronic pain that she had suffered for many years. The Ombudsman upheld Mrs T's complaint and found that:

- A&E clinicians failed to manage Mrs T's pain in accordance with recognised clinical guidelines

- Clinicians acted improperly and insensitively in advising Mr and Mrs T to return home and seek advice from their GP

- Mrs T's admission and receipt of treatment was delayed because clinicians could not agree on which department it was appropriate to refer her to

The Ombudsman recommended that:

a. The Health Board provides a fulsome, written apology to Mrs T and, in recognition of the distress caused to her, makes a payment to her in the sum of £500
b. The Health Board notifies lead clinicians of the need to ensure that patients, GPs and A&E clinicians are formally notified of any predetermined restriction on the admission of a patient, and that, in any event, the patient is clinically reviewed before the application of any such restriction
c. The Health Board shares this report with the A&E doctor(s) who advised Mr and Mrs T to return home

The Ombudsman also recommended that, within three months of the final report being issued:

d. The Health Board conducts an audit / review of the application and implementation of the College of Emergency Medicine Guideline for the Management of Pain in Adults 2010 among its A&E clinicians.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201203917 – Report issued December 2013

Mrs B, on behalf of her mother, Mrs M, complained about the care and treatment provided to her father, Mr M, during his admission to Nevill Hall Hospital over the weekend period 29 to 31 October 2010. Mrs M complained that the clinicians:

- Did not make the correct diagnosis
- Did not manage his pain
- Did not closely monitor his condition
- Did not operate urgently
- Did not move her father to the Intensive Care Unit (ICU) sooner

Mrs B was also unhappy with the communication between hospital staff and the family about Mr M's deteriorating condition.

Having obtained professional advice on the nursing, clinical and surgical aspects of Mr M's care, the Ombudsman **partly upheld** the complaint. The advice confirmed that Mr M had required urgent surgery and there was a failure to obtain senior surgical input which more than likely would have led to an urgent operation. There was no evidence that further tests which could have established the exact cause of Mr M's symptoms were carried out. There were also shortcomings identified in Mr M's pain management, his fluid balance charts were poorly completed and there was a lack of communication within and between the medical and surgical teams and with the family.

The Ombudsman recommended that the Health Board should:

- provide an apology to the family for the failings identified
- make a payment of £5,000 in recognition of ongoing distress to the family
- review the case and confirm what action had been taken to address the shortcomings identified

- ensure that an appropriate referral system is put into place between the medical and surgical teams
- provide training to and/or provide evidence of the training that had been provided to its staff members to improve communication
- review weekend working practices and consultant availability on the Assessment Unit to ensure that these meet the clinical needs of its patients
- remind nursing staff on the Assessment Unit of the importance of good record keeping
- review the skills mix of nursing staff to ensure that it is adequate to match the nursing needs of patients on the Assessment Unit and to benchmark it with equivalent clinical areas within Wales.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201202958 – Report issued December 2013

Mrs A complained about the Health Board's poor communication and inadequate record keeping which she said contributed to the poor care and treatment her late husband received. Mrs A said that it was only as a result of her persistence that her husband was referred to a specialist cancer unit. She was also dissatisfied with the manner in which she and her husband were informed that his condition was terminal. Finally, Mrs A complained about the Health Board's poor complaint handling.

The Ombudsman's investigation concluded that there was a failure to recognise the urgency of Mr A's condition and following the diagnosis of his cancer on 30 March 2010 a prompt and more effective clinical intervention would have ensured more effective management of Mr A's care.

The Ombudsman was also concerned that the Health Board's unduly blinkered approach resulted in a too narrow clinical focus on Mr A's diagnosis, to the detriment of his quality of life. He was of the view that the failure to communicate effectively or to provide sufficiently appropriate clinical review or palliative care; adversely affected Mr and Mrs A's quality of life in the period leading up to his sad death. Given these failings, the Ombudsman upheld this aspect of Mrs A's complaint.

The Ombudsman's investigation also identified inadequacies in record-keeping and found that the Health Board's responses to Mrs A's complaint significantly underplayed the extent of the Health Board's failings. Again the Ombudsman **upheld** this aspect of Mrs A's complaint.

The Ombudsman recommended that the Health Board should:

a) Issue a formal apology to Mrs A for the failings identified by the investigation and make a payment to her of £1,500, as an acknowledgement of the distress caused to her by failures in her husband's care which have been compounded by the shortcomings in the Health Board's complaint handling.

b) Share the content of the report with the Gastroenterologist and the Physician. The Health Board should confirm that this case has been critically reviewed as part of the Gastroenterologist and the Physician's annual appraisal.

c) In conjunction with the Cancer Network, review the Cancer Network's document for the Upper Gastrointestinal Cancer Clinical Care Guidelines in relation to required time lines for referrals to the Health Board's Surgical Out Patient Department and the UGI Cancer multidisciplinary team ("MDT").

d) Review its own Upper GI MDT processes in relation to responsibility for individual patient care, the surgical outpatient review and the referral to the MDT.

e) Document its adherence to the "Documentation of Outcomes" as listed in the MDT section of the Network Guidelines including the section on documentation, role of the key worker and the Cancer Nurse Specialist.
f) Audit the local MDT in relation to the "Documentation of Outcomes".
g) Bring this case to the attention of the South East Wales Cancer Network.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201202643 – Report issued November 2013
Mrs X complained about the care and treatment provided to her late husband, Mr X, when a patient at Royal Gwent Hospital. Mr X had advanced prostate cancer and other serious conditions. He sadly died during his admission in October 2011. Mrs X complained that it was inappropriate for her husband to have been left to toilet alone on a bed pan (when he fell); it was unreasonable for him not to have been cared for on the High Dependency Unit; the treatment for his prostate cancer was stopped too soon; the treatment provided had been inadequate; he had inappropriately been put on the end of life care pathway; and she had not been informed by staff that her husband was dying.

The investigation found that the medical care and treatment provided to Mr X had been of a reasonable standard but that there were shortcomings in the nursing care, specifically in relation to the risk assessments, care planning and evaluation and record keeping. The investigation found that it had been inappropriate to leave Mr X, in light of his condition, to toilet on the bedpan without assistance. This meant that he suffered a fall when he probably shouldn't have. This aspect of the complaint was **upheld**. The other aspects of the complaint were **not upheld**.

It was recommended that the Health Board:

(a) Provides a full and meaningful apology to Mrs X for not adequately protecting Mr X from the risk of falling when toileting on a bed pan.

(b) Reminds nursing teams about essential care planning and evaluation; the importance of accurate and properly completed risk assessments; and NMC guidance on record keeping.

The Health Board agreed to implement the recommendations.
Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201203738 – Report issued October 2013
Mrs H complained about hip surgery she underwent in April 2010. She complained that complications arose in the initial surgery which were not identified for several days due to a delay in an X-ray appointment over a Bank Holiday weekend. Mrs H

also complained about conflicting advice about bearing weight on the hip following surgery. Finally, Mrs H complained that she had been left choking on her own vomit and had to be resuscitated by a hospital porter.

The Ombudsman found that whilst the surgical complications were recognised ones, the delay in identifying them through X-ray was unacceptable. The Ombudsman was unable to find any record of the resuscitation incident to which Mrs H referred and could not therefore uphold that element of her complaint. The Ombudsman found examples of poor record keeping by staff.

The Ombudsman made the following recommendations

(a) That the Health Board should apologise for the failings identified;
(b) That the Health Board should review its Bank Holiday cover arrangements; and
(c) That the Health Board should remind staff of the importance of accurate record keeping.

September 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mrs A complained about the care provided to her mother, Mrs E, whilst she was an inpatient on the Health Board's Elderly Mentally Infirm ("EMI") ward between March and August 2011. In particular, Mrs A felt that the Health Board had not taken sufficient measures to keep her mother safe and prevent a series of falls which culminated in her mother fracturing her femur. Finally, Mrs A was dissatisfied with the Health Board's subsequent handling of her complaint.

The Ombudsman's investigation found that in Mrs E's case the falls assessments that the Health Board had carried out were not sufficiently robust. For example, there was not enough recognition by medical or nursing staff of the risk Mrs E's medication, prescribed whilst she was on the EMI ward, continued to pose in terms of Mrs E sustaining falls. The investigation concluded that it was possible that more robustly completed falls assessments might have resulted in more effective strategies (including medication interventions and reviews) being put in place which might have reduced the likelihood of Mrs E falling. This aspect of Mrs A's complaint was therefore upheld.

The Ombudsman's investigation found that the Health Board's complaint handling had been marred by poor communication, delays and a lack of robustness in the investigation process. Again, this aspect of Mrs A's complaint was upheld.

The Ombudsman made the following recommendations. Within one month of the report being finalised the Health Board's Chief Executive should:

(a) apologise for the failings identified in the report. In addition, to reflect the uncertainty of not knowing whether with a proper assessment Mrs E's fall might have been prevented, as well as the shortcomings in complaint handling, the Health Board should make a payment of £1500 to Mrs A, on behalf of the family.

The Health Board should within three months of this report being finalised provide evidence:

(b) of the measures it had put in place to ensure that there were regular reviews of medications, especially sedatives and psychoactive drugs at its EMI unit and that a mechanism existed to feed this into any falls assessment

(c) that it had introduced a system of regular audits and training on the effects of sedatives and psychoactive drugs on falls and the risk they posed in terms of falls at the EMI

(d) that it had revised its adverse or serious incidents reporting procedure so that in the case of the EMI where a patient falls, the possible correlation between the patient's medication and their fall was examined and any lessons learnt implemented. The results should be reviewed annually and presented to the appropriate Quality and Patient Safety Committee.

Case reference 201202402

September 2013 – Other – Aneurin Bevan Health Board

Mrs D complained about the care provided by Aneurin Bevan Health Board ("the LHB") in November 2012, when she was admitted to the Royal Gwent Hospital for an induced birth. Mrs D said that:

- she had to labour on the main ward with other people around her; she said this affected her dignity;
- she felt her baby was put at risk because she was not monitored;
- she was not given appropriate pain relief;
- her named midwife should not have been called away to care for another patient;
- she disagreed with the version of events given by the LHB about the point at which a discussion about an epidural took place.

Along with the evidence gathered, the investigation considered the National Institute for Clinical Excellence ("NICE") guidance on intrapartum care and the Induction of Labour ("the NICE Guidance"). The Ombudsman also obtained advice from an experienced Consultant Obstetrician.

The guidance does not make recommendations about whether women should be delivered in a private room. The investigation found that Mrs D was transferred to the main delivery unit at a clinically appropriate point in her labour. The investigation also concluded that the monitoring that took place during labour met professional guidance and there was no evidence that Mrs D and her baby were put at risk. The investigation concluded that, although Mrs D was unhappy with the pain relief offered to her, it was clinically appropriate.

During her care, Mrs D's named midwife was also responsible for several other women. The decision that the midwife should accompany another patient who was being transferred was made based on clinical risk and clinical priorities. The investigation found that this was appropriate and that the care Mrs D received was not compromised as a result of the change in midwife.

Mrs D's complaint about the care provided by the LHB was not upheld. However, the investigation did identify that the explanation given by the LHB to Mrs D about

the point at which a discussion about an epidural took place was incorrect. Therefore this aspect of Mrs D's complaint was upheld. The LHB agreed to:

- give Mrs D a written apology for the inaccuracy which was included a letter to her;
- review and, if necessary, amend, the process for escalation when a patient requests a doctor's review.

Case reference 201203805

September 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mr A complained about the care and treatment provided to his wife during a period of 10 weeks whilst she was an inpatient at Ysbyty Ystrad Fawr, a local general hospital with an integrated mental health unit. Mr A felt that his wife's physical and mental health needs were not adequately managed during this period. In particular, Mr A raised concerns about the failure of staff to take action or to consider alternatives for her when she refused medication and food for a period of five weeks. Concerns were also raised about the management of his wife's psychiatric treatment and aspects of the nursing care provided. Mr A complained also about the adequacy of the Health Board's investigation of his complaint.

The Ombudsman's investigation found that there was a failure to review the management of Mrs A's medication and nutrition during the period when she had refused medication and treatment. The Ombudsman was satisfied that the care provided to Mrs A during this period was below an acceptable standard. The investigation also identified failings in respect of the assessment of Mrs A's falls risk and in the assessment and management of her pressure areas. The Ombudsman concluded that a decision not to provide a specific form of psychiatric treatment was appropriate. The Health Board itself acknowledged a number of shortcomings in the initial investigation of Mr A's complaints.

The Ombudsman recommended that the Health Board apologise to Mr and Mrs A and make a payment of £1000 in recognition of the failings identified in the report. In addition, the Ombudsman asked the Health Board to conduct an analysis of care to determine what lessons could be learned from Mrs A's case. It was also asked to review its falls risk assessment policy.

Case reference 201203086

August 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mrs B complained about the treatment her daughter, E, received in hospital. She complained that there had been a delay in arranging for E to have a vaccine which had been identified as being beneficial to her. Mrs B said that this may have led to E subsequently having a seizure. Mrs B also complained that there were delays in transferring E from the ward to the Radiology Department for a CT scan and that by the time she arrived for her scan, the sedative she had been given had worn off, necessitating a further dose. Mrs B was concerned at the health implications of this second dose.

The Ombudsman found that the short delay in arranging for the vaccine was not clinically significant and that E's seizure was entirely unconnected with her earlier illness and hospital admission. Whilst the Ombudsman found that the doses of

sedative given were well within recommended limits, he criticised the communication between wards which delayed the CT scan. The Ombudsman recommended that the Health Board should apologise to Mrs B and improve procedures for transferring sedated patients between wards for investigative scans.
Case reference 201203772

July 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mr B complained about his mother's treatment at the Royal Gwent Hospital and, later, at the County Hospital. He said that there was a failure in communication, both between professionals themselves and between professionals and family members, and a failure to ensure that his mother received adequate nutrition. He also complained about the way in which his complaint was investigated under the Protection of Vulnerable Adults ("POVA") procedures and about the adequacy of the Health Board's response to his complaint. Sadly, Mrs B died in July 2010.

The Ombudsman partly upheld the complaint. He found that Mrs B generally received appropriate clinical and nursing care. Although she had not been weighed regularly and had clearly not received adequate nutrition, this was not because of nursing failings and staff could not have done anything to prevent her death. However, there had been confusion amongst staff members about the type of diet which was suitable for Mrs B, and contradictory information about this had been given to family members, who had not been adequately supported in their efforts to feed her. The Ombudsman also found that there had been a considerable delay in carrying out the POVA investigation, and that there were omissions in the Health Board's response to Mr B's complaint.

The Ombudsman recommended that the Health Board:

- apologise to Mr B for the failings;
- pay the sum £500 in recognition of the failings in communication, and of Mr B's time and trouble in pursuing the complaint (at Mr B's request, the payment is to be made directly to the Alzheimer's Society);
- remind staff of the importance of maintaining good communication;
- issue guidance to staff on the use of the MUST nutrition tool;
- issue guidance to staff on record-keeping.

The Health Board agreed to implement these recommendations.
Case reference 201201479

June 2013 – Appointments/admissions/discharge/transfer procedures – Aneurin Bevan Health Board
Ms A complained about the care her late father, Mr A received during his admissions to both the Royal Gwent Hospital and Chepstow Community hospital.
The investigation found that the Health Board failed to notify the ambulance crew who transferred Mr A of his decision not to be resuscitated in the event of a cardiac arrest, in accordance with the Health Board's policy.

Whilst communication with Ms A and Mr A's care and treatment was found to be of a high standard the investigation found that there was evidence of a failure to adequately communicate Mr A's nutritional needs to ward staff; that doctors had

failed to record a number of examinations in Mr A's medical records; and that Mr A was transferred to the Royal Gwent Hospital without clean clothes, toiletries and his walking stick and glasses.

In October 2011 the Health Board undertook a "best interests" assessment and identified a need for a placement in a particular care home with expertise in caring for elderly patients with dementia. Following this assessment the health professionals led Ms and Mr A to believe that there would be a place for Mr A at the identified care home. However, when Mr A's condition deteriorated in March 2012 the Health Board then presented Ms A with its "Choice Policy" which required her to identify three suitable care homes for her father. The investigation found that the Health Board should have informed Ms A of this policy in October 2011 when it initially assessed Mr A.

Finally, the investigation found failings in the Health Board's approach to Ms A's complaints which resulted in delayed and incomplete responses being given. Also, it nominated a member of staff to deal with all of Ms A's concerns who had previously stated that she could not deal with Ms A as a result of a conflict of interest.
Case reference 201200142

June 2013 – Clinical treatment outside hospital – Aneurin Bevan Health Board
Mrs A complained about Aneurin Bevan Health Board regarding a home visit by a locum GP, which it employed on a sessional basis, to her late husband. Mrs A said that the GP did not examine Mr A thoroughly and therefore did not identify that he was suffering from high blood sugar and pneumonia. Mr A went to hospital soon after the visit. Mrs A also said that the GP's record of the consultation was inaccurate.

The Ombudsman found that, despite the failure to diagnose the extent of Mr A's ill-health, the consultation was within the bounds of acceptable clinical practice. The Ombudsman accepted that there was evidence that the notes of the consultation were insufficiently robust. He therefore, upheld the complaint about record keeping to an extent. The Ombudsman recommended that the Health Board write to the GP, requesting that he reflect on his comments about record keeping and the content of the report generally. The Health Board accepted the recommendation.
Case reference 201203161

June 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board

Mr and Mrs Z complained about the events surrounding Mr Z's operation on his elbow as well as his post-operative care. Mr and Mrs Yemm also complained about the length of time taken by Aneurin Bevan Health Board ("the LHB") to respond to their complaints.

With respect to the events leading up to Mr Z's operation, the investigation found that Mr Z underwent a full pre-operative assessment with a Consultant Anaesthetist and appropriate recommendations were made and incorporated into the operation plan. Additionally, Mr Z was given all of the information necessary in order to make an informed decision about the risks associated with general anaesthetic which he later considered with his family.

Following the operation Mr Z experienced a number of complications including an exacerbation of his respiratory failure, renal failure and his cannula tissued. These issues were appropriately dealt with as soon as they had been identified. This element of the complaint was not upheld.

With respect to Mr Z's discharge from hospital, there was no evidence of a discharge plan in Mr Z's medical records, and the LHB accepted that Mr Z's discharge should have included ambulance transport. The element of the complaint was upheld.

Mr Z was referred to the District Nursing Service following his discharge from hospital the LHB has accepted that when the initial telephone referral was made, the District Nursing Service had only been informed of Mr Z's post operative wound, not the blisters on his legs. This resulted in Mr Z having to wait an extra day to have his blisters treated. This element of the complaint was upheld

Finally having raised additional concerns with the LHB following their initial response to your complaint, it took almost 12 months for the LHB to respond. This element of the complaint was upheld.

It was noted that the LHB had not only recognised and undertaken work to improve its service in these areas it also agreed to implement the following recommendations:

- the LHB apologise to Mr and Mrs Z for the failings identified in this report.
- the LHB pay Mr and Mrs Z £750 in recognition of the failings identified in the report.
- the LHB remind the relevant staff of the Ambulance Transport Booking Policy.
- the LHB remind the relevant staff of the LHB's obligations under its "Putting Things Right" policy.

Case reference 201103922

April 2012 – Other – Aneurin Bevan Health Board

Mrs P complained that she and her family experienced unacceptable delays and difficulties when responsibility for her severely disabled son M's care transferred from child to adult services with Aneurin Bevan Health Board. In particular, she was concerned that there was an unreasonable delay in organising suitable respite care. Mrs P was also concerned about the way her complaint was dealt with.

The Ombudsman found that not all the delays and difficulties were due to the actions of the Health Board; however, he considered that there were some failings on its part. These included that the transition process should have started sooner than it did; an assessment of whether M was eligible for NHS funded continuing care was flawed; there were some avoidable delays in arranging a suitable respite placement; and communication with Mrs P was not as good as it should have been. The Ombudsman was also critical of the fact that the Health Board had continued to deal with Mrs P's complaint informally after she had explicitly asked for it to be considered under the formal NHS complaints procedure.

The Ombudsman upheld Mrs P's complaints to the extent of the failings identified. He recommended that the Health Board should apologise to Mrs P and pay her £500 to recognise the additional stress, time and trouble and worry she had been caused. He also recommended that the Health Board should provide the family with an additional six weekends of respite over the next 18 months to make up for the sessions M did not have. The Health Board agreed to implement the recommendations. The Ombudsman recognised that the Health Board had already acknowledged failings in this case and he noted in particular that it had now introduced an appropriate policy for dealing with transition cases.

Case reference 201201350

Other reports - Not Upheld

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201301667 – Report issued March 2014
Ms H complained about her care and management by an Orthopaedic Consultant at the Health Board and about its handling of her complaint. Specifically, she complained that, having been formerly treated for Perthe's disease as a child (characterised by an interruption to the blood supply of the hip joint's femoral head [ball part of the hip joint]; part of the femoral head dies so that ball is unable to rotate feely in the hip socket so restricting movement and risking future arthritis; in extreme cases a hip replacement is required), that investigations (including X-rays) should have been undertaken sooner to diagnose her problems, and alleviate her pain. She had been discharged from orthopaedic care in childhood and first saw the Consultant aged 21. She had lost confidence in the treating Consultant and personally paid for private chiropractor sessions, orthopaedic consultations elsewhere and post surgical physiotherapy. She was found to need urgent bone conservation treatment to avoid a full hip replacement- albeit this could only be performed when she had given birth. Ms H was at the time 26 years old and complained that earlier X-rays and interventions by the Consultant may have resulted in earlier treatment and avoided her pain and financial loss.

The investigation did not uphold the complaints against the Health Board Consultant's care of Ms H. The Ombudsman's professional adviser confirmed that Perthe's disease is still an evolving clinical area and that childhood approaches might now differ from when Ms H was young. Having reached maturity it was still unclear if late interventions could avoid some of the problems associated with Perthe's disease. Only two specialists in the UK undertook the procedure Ms H eventually underwent. The Consultant's approach was not wrong. No earlier X-ray was mandated as they are only warranted where there are clinical reasons for performing them. There were none when Ms H first saw the Consultant aged 21. When she was seen a year later for review an X-ray was performed, showing changes to the hip, and a CT was booked. However the CT had to be cancelled when as Ms H was pregnant. No further investigations or interventions could be conducted until the birth. Ms H then elected to seek a private consultation elsewhere and eventually the hip conservation procedure was performed by a specialist in England (funded by the Health Board).

The Ombudsman found that the care and management of Ms H was within the bounds of acceptable clinical practice, and reasonable; particularly given it was an area of evolving clinical care. She did **not uphold** the complaint. In relation to complaint handling, the Ombudsman **upheld** this aspect **in part** as there were some delays in responding to Ms H albeit the responses provided dealt with the issues reasonably well. A resolution meeting had also been held. The Health Board agreed to the Ombudsman's recommendation to apologise to Ms H for the complaint handling delay.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201300589 – Report issued January 2014
The investigation considered the adequacy of Mrs X's clinical care in 2011 at the Royal Gwent Hospital, and whether her deterioration could have been avoided. She

had been admitted with respiratory problems and sadly died just over two weeks later.

The investigation found that Mrs X was very ill with a number of health problems, many of which had not been apparent before she was admitted to hospital. Therefore the seriousness of her condition and her sad, and relatively sudden, death came as a shock to the family. It was disappointing that her diagnosis and the clinical challenges were not made clearer to family members who were visiting Mrs X regularly. However, the Ombudsman found that there were no failings in Mrs X's care that would have led to any different outcome. Her medical care was appropriate to her complex condition and the management of her oxygen levels was reasonable, although the family had found her without oxygen on occasions.

While the Ombudsman did not uphold the complaint, the Health Board was notified of issues relating to a failure to obtain a bariatric bed for Mrs X, and staff shortages on the ward.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201202753 – Report issued October 2013
Mrs W complained to the Ombudsman about a failure on the part of Aneurin Bevan Health Board to diagnose her late husband's cancer in a timely manner and that the subsequent planning and management of his medical and general needs were inadequate. She also complained about aspects of her husband's pain management and about failure to provide adequate food, drink and analgesia on a particular occasion.

The Ombudsman found that the diagnosis, and subsequent management and treatment of Mr W's condition had been reasonable. He did not uphold the complaint. The Ombudsman was unable to uphold Mrs W's complaint about a failure to provide Mr W with sustenance and analgesia when he was waiting in the radiology unit on one specific occasion.

July 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board
Mrs W complained that she experienced further hearing and balance difficulties following a "Left Tympanoplasty" (an operation to eradicate disease from the middle ear) carried out at the Royal Gwent Hospital in 2010. She complained that her informed consent to the procedure was not obtained; she also complained about the management of her condition following the operation.

Having obtained professional advice, the Ombudsman did not uphold the complaint. The Ombudsman found that, on balance, the evidence suggested that Mrs W's informed consent had been obtained and that the associated risks of the procedure were fully explained to her before the operation. There was nothing to suggest that the operation had been incorrectly performed and the Ombudsman concluded that the complications experienced by Mrs W following her surgery were recognised risks of the operation that were fully explained to her beforehand. Finally, the Ombudsman found that the post-operative care received by Mrs W was appropriate and that more prompt and/or alternative intervention or treatment would not have altered her present condition.
Case reference 201203249

April 2013 – Clinical treatment outside hospital – Aneurin Bevan Health Board
Mr Y complained about the care and treatment provided to him by the Health Board. He was of the view that the Royal Gwent Hospital failed to diagnose his health condition, offer adequate treatment, and carry out a colonoscopy within a reasonable timescale, particularly following a referral from his GP.

Mr Y had suffered with bowel problems for a number of years and he underwent a series of investigations between 2006 and 2011 including blood tests, barium X-rays, CT scan, flexible sigmoidoscopies (including biopsy) all of which failed to explain his on-going problems with diarrhoea and rectal bleeding.

Mr Y said that it was as a result of this failure to diagnose his condition that he sought a private consultation in September 2010 and was given a possible diagnosis of Colitis or Crohn's disease. He was told that he would need a colonoscopy to confirm this.

Around this time the Health Board clinicians had planned a further barium enema test which did not show any abnormality and as Mr Y had continuing symptoms a CT enterogram was also organised which also did not identify any abnormality.

The Health Board decided that on the basis of investigations including negative blood tests that a colonoscopy was not indicated. When the GP raised this on a further occasion Mr Y was added to the outpatients list for a routine appointment.

As a result of Mr Y's concern about the possibility of a delay in receiving the procedure, he underwent a private colonoscopy which confirmed Crohn's disease in December 2011. Mr Y considered that this procedure should have been made available to him by the Health Board.

Taking account of clinical advice the Ombudsman found that the investigations carried out by the Health Board were logical and appropriate and would ordinarily find most cases of Crohn's disease. He found that the tests undertaken were reasonable alternatives to a colonoscopy. He also said that it was reasonable for the Health Board to rate the GP referral as routine priority as it contained no new clinical information.

The Ombudsman found that the clinicians struggled hard to diagnose Mr Y's illness over a long period and although there was a failure in achieving a satisfactory diagnosis this was not as a result of inadequate investigation and review.

It was very unfortunate that Mrs Y's particular situation was most unusual and that the relevant diagnostic procedures undertaken failed to identify any abnormalities.

The Ombudsman did not uphold the complaint.
Case reference 201201233

Quick fixes and Voluntary settlements

Aneurin Bevan Health Board – Complaints Handling (Health)
Case reference 201306196 – March 2014
Mr A complained that the Health Board had referred his complaint about his dental treatment to his dental practice to investigate. Mr A said that the Health Board had not fully explained that it could not consider the complaint once the dental practice had investigated the matter. Mr A said that he did not want this confusion to occur for other complainants in future.

Having considered the information provided, the Ombudsman found that the Health Board's decision to refer Mr A's complaint to the dental practice was not inappropriate. However, the Ombudsman approached the Health Board on the basis that it had not made it entirely clear to Mr A that once the dental practice had responded to the complaint it could not consider it, in accordance with the Welsh Government's complaints handling guidance "Putting Things Right".

The Health Board agreed to include an appropriate paragraph within its acknowledgment letter and/or consent form to ensure that this is made clear to complainants in future cases. The Ombudsman concluded that the action which the Health Board said it would take was reasonable to settle the complaint and closed the file on this basis.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201306586 – March 2014
The substance of Miss A's complaint related to her treatment and care at the Day Surgery Unit, Royal Gwent Hospital. However, in her letter of complaint to the Ombudsman, she also raised new concerns about the lack of treatment options currently available to her.

In view of Miss A's ongoing concerns, the Health Board agreed to arrange for another clinician to assist with a second opinion in relation to further treatment options that may be clinically appropriate for her.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201304027 – February 2014
The complainant was unhappy that the Health Board had not fully considered his complaint and, because he had sought legal advice, he had subsequently been advised that he could not complete the 'Putting Things Right' (PTR) complaint process.

Following contact from the Ombudsman's office, the Health Baord agreed to complete the complaint investigation through the PTR process.

Aneurin Bevan Health Board & Powys Teaching Health Board – Continuing care
Case reference 201304079 & 201304744 – January 2014
Mr A's solicitors complained on his behalf about the refusal to reimburse care home fees for the late Mrs B. Mrs B was assessed as being eligible for NHS Funded Continuing Care from 1 April 1999 to 26 December 2002. The refusal to reimburse the fees was on the basis that the proofs of payment were insufficient. Mr A's

solicitors said that the request for further proofs of payment was unreasonable as, due to the passage of time, none existed.

The investigation considered the information provided by Mr A's solicitors, Aneurin Bevan Health Board and Powys Teaching Health Board (the Health Boards). During the course of the investigation, the Welsh Government issued "Interim Guidance on Reimbursement for Retrospective Claims processed by the Powys Project" (the guidance, issued in December 2013). The Ombudsman approached Aneurin Bevan Health Board on the basis that its stance appeared unreasonable, particularly in light of the guidance. Aneurin Bevan Health Board agreed to settle the complaint by dealing with the claim in accordance with the guidance.

July 2013 – Other – Aneurin Bevan Health Board
Mr and Mrs D complained that the Health Board made a groundless Protection of Vulnerable Adult ("POVA") referral concerning their disabled adult son. Thereafter, it did not completely vindicate them or address all their concerns in its complaint response, despite agreeing that the Health Board should have done more to verify its concerns before making the referral.

The Ombudsman's initial considerations were that, whilst an authority should make a referral if it had concerns, the Health Board had not fully remedied the injustice that it had itself identified. He considered that the referral might not have been made with better groundwork and some other issues were not fully or correctly explained in the Health Board's complaint response. He found that record keeping regarding the referral lacked clarity.

The Ombudsman submitted the following proposal for settlement:

- the Health Board make a payment of £350 to Mr and Mrs D for uncertainty that the referral was necessary;
- issue a letter of clarification to Mr and Mrs D on various points; and,
- feedback to staff regarding record keeping.

The Health Board accepted the proposal.
Case reference 201204292

June 2013 – Continuing care – Aneurin Bevan Health Board
Ms F complained that her client's retrospective claim for the reimbursement of care home fees for the period 1996 - 2000 was unreasonably rejected by the Health Board. Ms F complained that the Health Board accepted that her client had been a resident at the care home and was eligible for his fees to be paid by the NHS, but would not settle the claim as receipts and invoices for payments made to the care home had been destroyed, due to the passage of time. Ms F complained that the Health Board would not accept a number of bank statements which showed regular payments by cheque, together with a signed statement from a former member of staff from the care home, as evidence that her client had paid his fees.

The Ombudsman considered the Health Board's position to be unreasonable. He concluded that although the exact sums paid could not be established, it was possible to calculate and negotiate a reasonable settlement. The Ombudsman asked the

Health Board to enter into such negotiations with the complainant's representative and to reach a compromise settlement, which reflected both the eligibility and the lack of definitive financial evidence. The Health Board agreed to do so and to make settlement on a without prejudice basis. The Ombudsman considered this to be a reasonable resolution.
Case reference 201203303

May 2013 – Clinical treatment in hospital – Aneurin Bevan Health Board
The complainant was unhappy that, following a meeting, the Health Board agreed to write to the complainant but had yet to do so. Following contact from my office, the Health Board agreed to respond to the letter within two weeks.
Case reference 201300017