Our ref: MG/jm
Ask for: James Merrifield

Your ref:
01656 644 200

Date: 15 July 2014
James.Merrifield@ombudsman-wales.org.uk

Mr Adam Cairns
Chief Executive
Cardiff and Vale University LHB
Cardigan House
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Heath Park
Cardiff
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Dear Mr Cairns

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 Cardiff and Vale 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, but a decrease in the number of complaints investigated, compared to 2012/13. The largest single area of complaints remains 'clinical treatment in hospital', whilst there has also been a noticeable increase in the number of complaints relating to 'complaint-handling'. My office has issued three Public Interest Reports against your Health Board during 2013/14, which is also well above the health body average – the summaries of these reports are enclosed. I am pleased to note an above-average number of quick fixes and voluntary settlements. However, it is disappointing that just under two-thirds of your Health Board's 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, Cardiff and Vale 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.

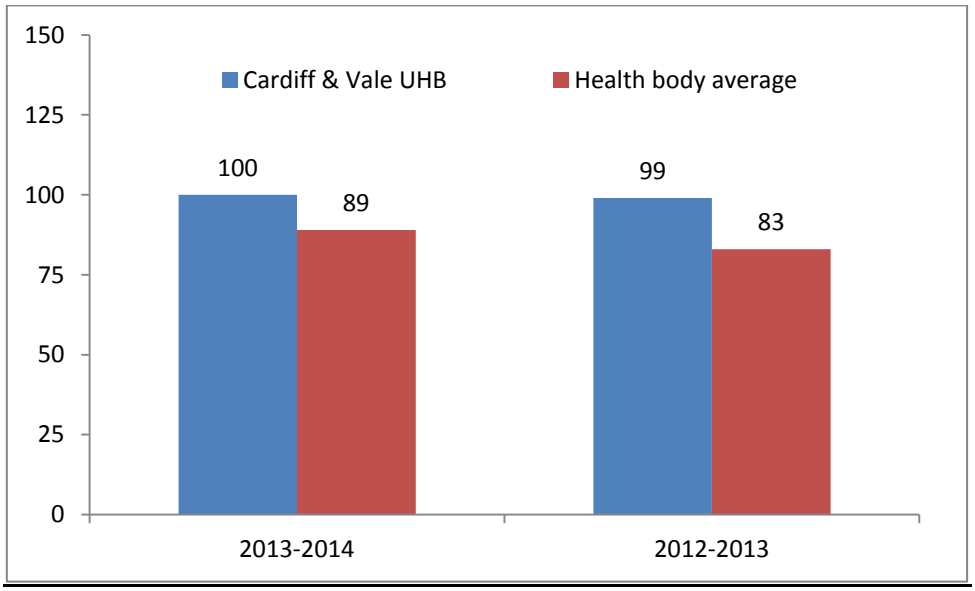
Section E compares the number of complaints against the Health Board which were taken into investigation by my office in 2013/14, with the average for health bodies (adjusted for population distribution) during the same period.

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

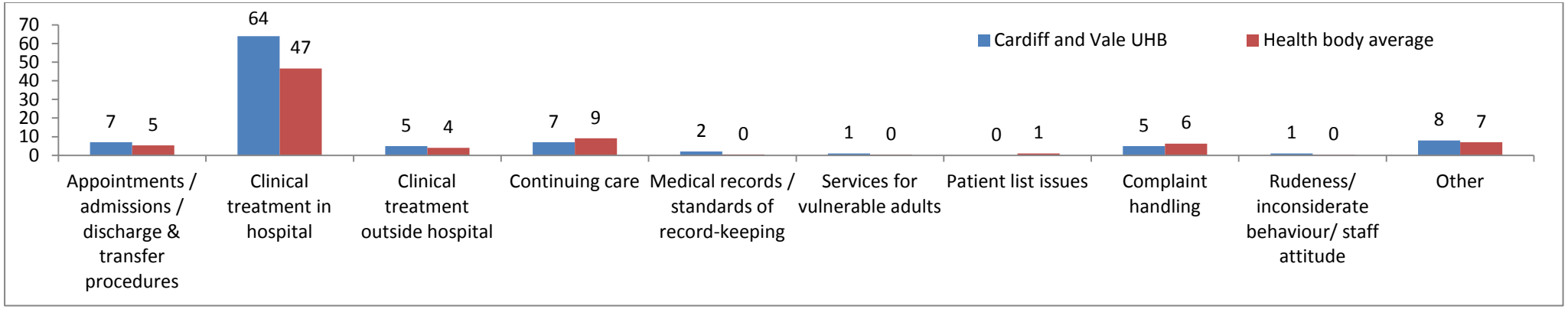


B: Complaints received by my office

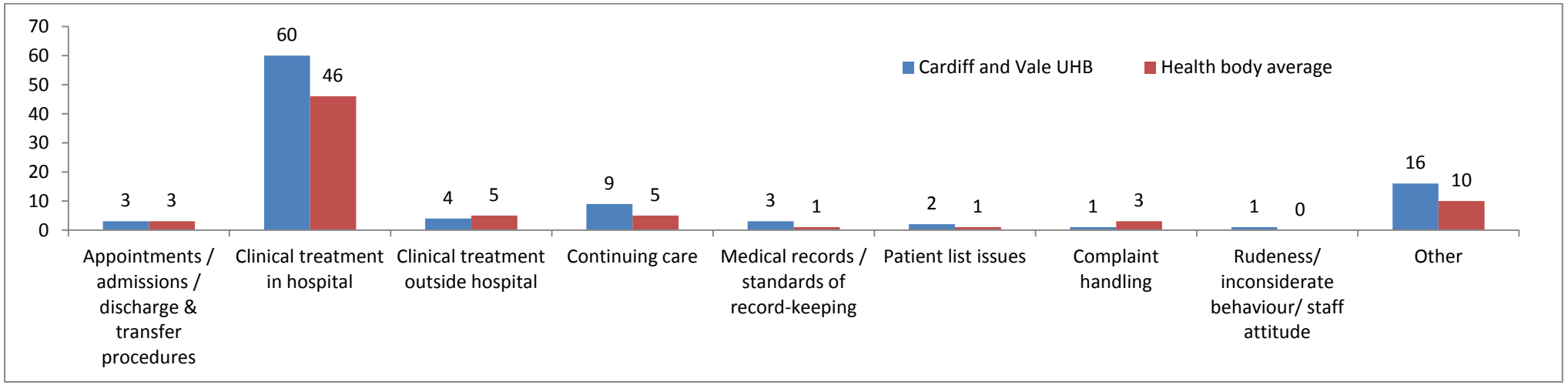
Subject	2013/14	2012/13
Appointments/ Admissions/ Discharge and transfer procedures	7	3
Clinical treatment in hospital	64	60
Clinical treatment outside hospital	5	4
Continuing care	7	9
Medical records/ standards of record-keeping	2	3
Services for vulnerable adults	1	0
Patient list issues	0	2
Complaint-handling	5	1
Rudeness / inconsiderate behaviour / staff attitude	1	1
Other	8	16
TOTAL	**100**	**99**

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

2013/14



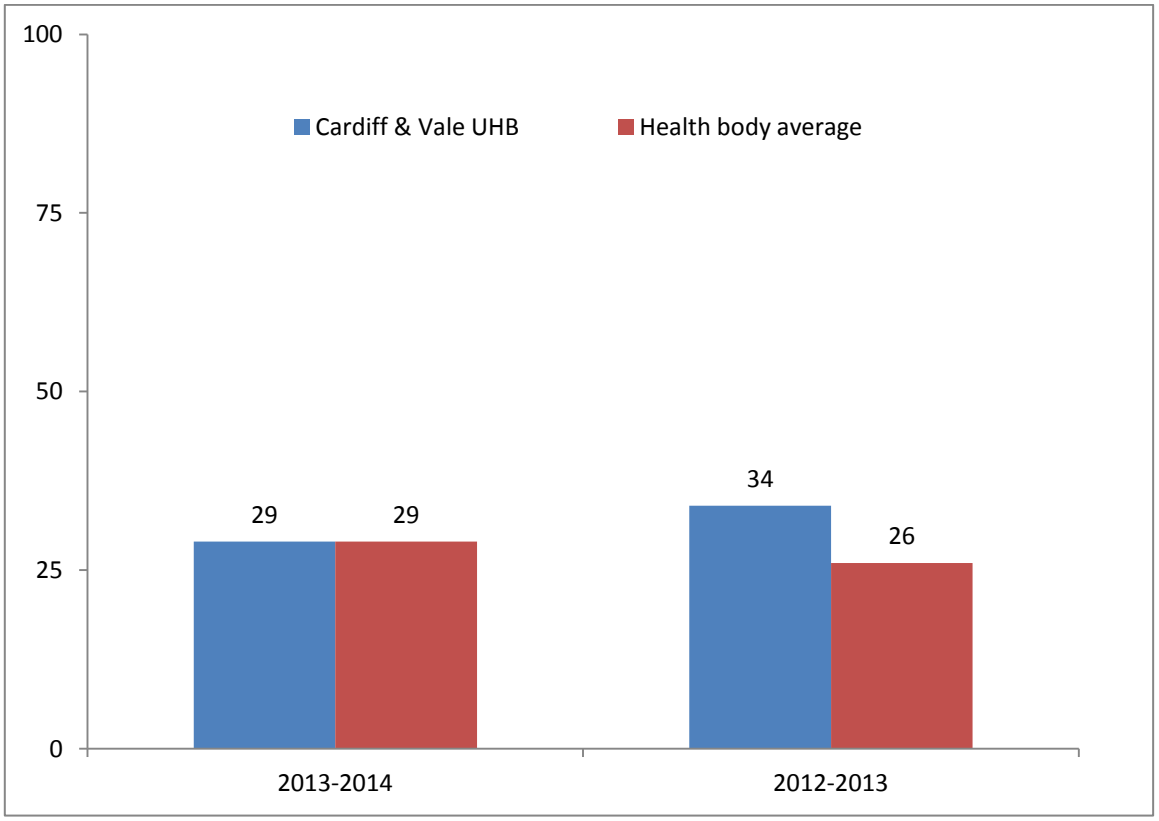
2012/13



D: Complaints taken into investigation by my office

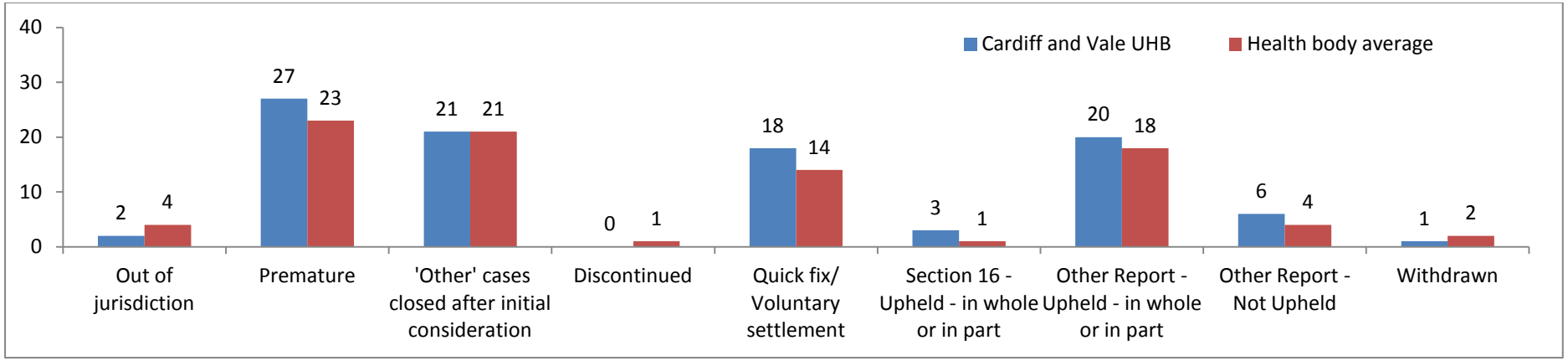
	2013/14	2012/13
Number of complaints taken into investigation	29	34

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

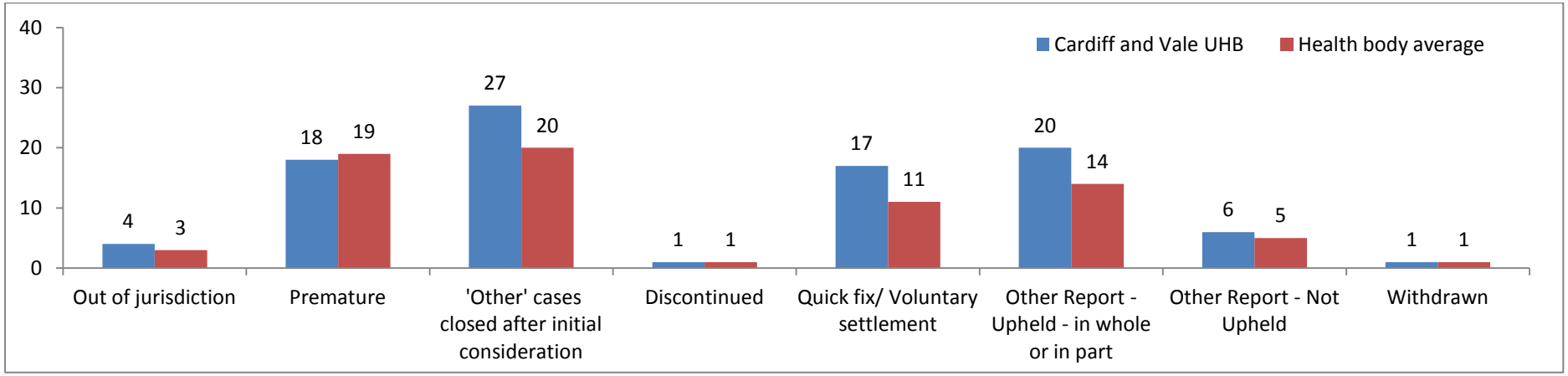


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

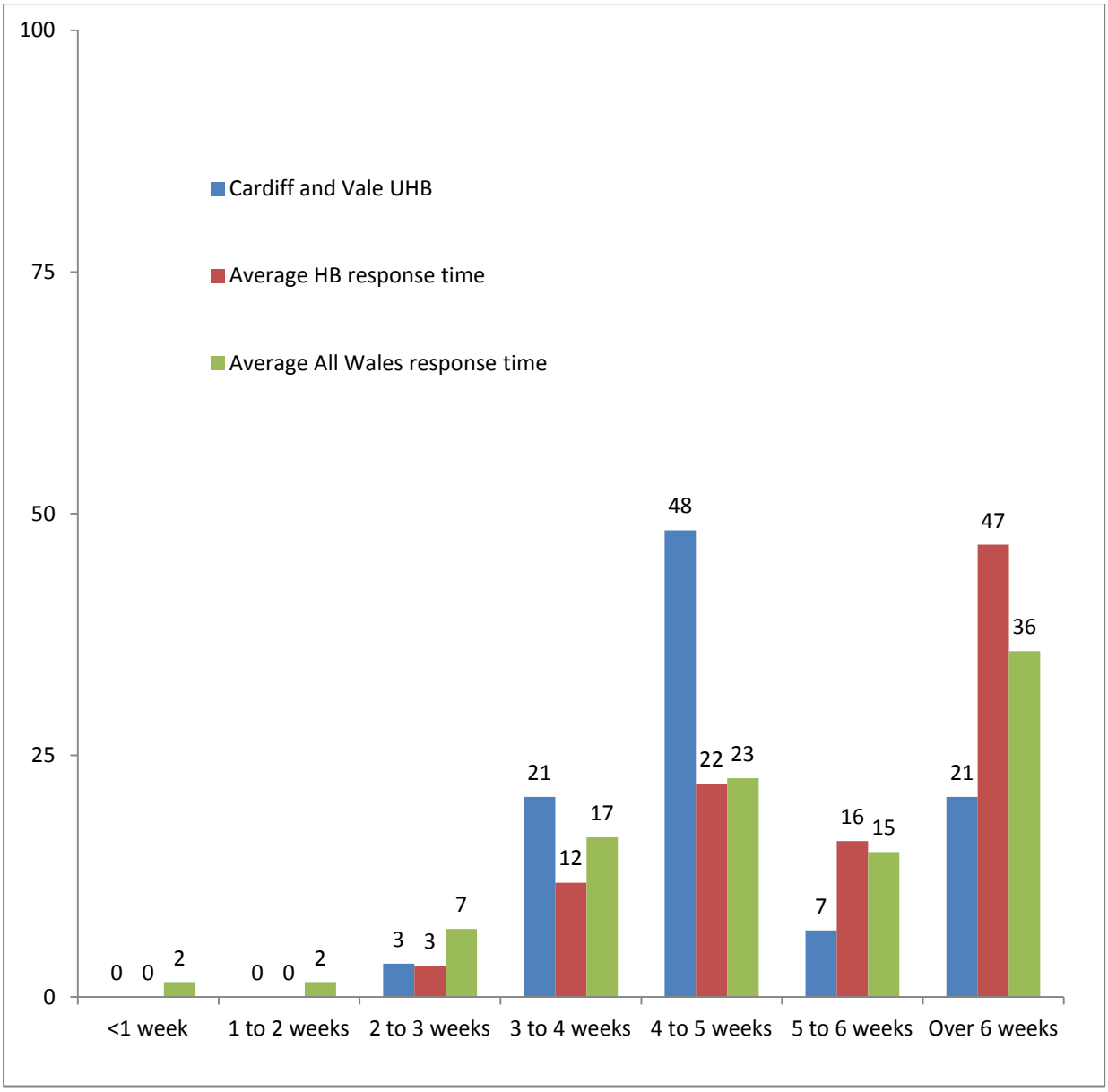
2013/14



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

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201204130 – Report issued February 2014

Mrs T complained about the treatment her husband, Mr T, received in hospital. She complained that he received excess intravenous fluids and that this fluid overload caused subsequent health problems, including multiple strokes, from which he sadly died in May 2011. Mrs T also complained that errors were made in her husband's medication when admitted to hospital, that the diagnosis of his stroke was delayed and that had he received appropriate and timelier treatment, he may have survived.

The Ombudsman found that the instance of fluid overload was not clinically significant in terms of the sad outcome. However, the Ombudsman upheld Mrs T's complaint, finding that the Health Board had failed to act in accordance with national guidelines for the treatment of stroke. The Ombudsman concluded that errors were made with Mr T's regular medication and that opportunities to diagnose Mr T's stroke and to implement treatment which may have increased his chances of survival were missed.

The Ombudsman recommended that the Health Board should:

1. Issue to Mrs T and her family a comprehensive apology for the failings identified in this report.

2. Review its arrangements in respect of post-admission medication reconciliation and ensure that a systematic medicine reconciliation programme is in place.

3. Ensure that staff training in respect of recognising acute stroke is up to date, with particular reference to the 2012 Stroke Guidelines issued by the Royal College of Physicians.

4. Ensure that use of the Rosier score system (or a similarly recognised tool), in order to identify patients who are likely to have had an acute stroke, is implemented.

5. With particular reference to the current Stroke Guidelines and NICE guidance, review its arrangements for the identification and treatment of acute stroke and consider including the following measures:

   a) All patients who may have had an acute stroke (i.e. have been assessed as having a positive Rosier score) should be immediately assessed by a physician trained in stroke medicine to determine whether thrombolysis is suitable;

   b) Suitable patients should have immediate CT scanning and, in all cases, within one hour.

c) All patients who may have had an acute stroke should be admitted immediately to a specialist acute stroke unit.

d) All patients who may have had an acute stroke should have a swallowing screening test, using a validated tool, by a trained professional within four hours.

6. Review the findings set out in its various complaint responses to Mrs T and to this office and take action to ensure that its own complaints investigations are in accordance with the Putting Things Right scheme, are sufficiently robust, demonstrably independent and, where appropriate, critical of identifiably poor care, which should include the introduction of a quality assurance audit of a sample of its completed complaint investigations.

7. Issue to Mrs T a cheque in the sum of £5000 in respect of the time and trouble to which she has been put in pursuing this complaint and in recognition of the additional distress caused to her and her family as a result of the uncertainty with which they now live over whether Mr T might have survived the initial stroke.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201202432 – Report issued October 2013

Ms D complained that midwives at the University Hospital of Wales (UHW) wrongly informed her that her pregnancy dating scan[1] revealed that she had suffered a 'silent' miscarriage. This error was detected only because Ms D elected to undergo uterine evacuation at a different hospital. There, a more thorough type of scan (a trans-vaginal [tv] scan) was performed which detected a healthy, viable foetus.

The Ombudsman upheld Ms D's complaint and found that the Health Board had failed to implement guidelines issued by the Royal College of Obstetricians & Gynaecologists (RCOG) that were designed to prevent the misdiagnosis of early pregnancy loss. These guidelines require midwives to conduct a TV scan in all such cases. The Ombudsman also found that the initial dating scan had been incompetently conducted and that midwives failed to take account of Ms D's relevant medical history. The Ombudsman recommended that:

(a) The Health Board provides Ms D with a written apology and, in recognition of the inconvenience and expense incurred in obtaining alternative antenatal care, makes a payment to Ms D in the sum of £1,500.
(b) Further to the Health Board agreeing to take immediate steps to implement RCOG guidance in respect of the diagnosis of early pregnancy loss and to promptly notify all relevant clinicians within the Directorate that it has done so, it provides documentary evidence of how this process was accomplished.
(c) The Health Board provides evidence that it has reviewed / assessed the competence of its midwife sonographers in respect of the diagnosis of silent miscarriage.
(d) The Health Board shares with the Ombudsman the outcome of its complaint investigation review of this case (its Root Cause Analysis).

April 2013 - Continuing care - Cardiff and Vale University Health Board
Solicitors complained on Mrs S's behalf that the Cardiff and Vale University Health Board had failed to administer matters in relation to her mother Mrs W's claim for continuing health care correctly. Mrs W had been in a nursing home since 2002 and was receiving funding for the nursing element of her costs. Her home had been sold to pay for the remaining element of her care home fees.

The Solicitors submitted evidence which they said showed that there had been delay and error in dealing with Mrs W's assessments for continuing health care and that the Independent Review Panel had also not dealt with matters properly. They alleged that this situation had led to injustice to Mrs W through delay and financial loss.

The Ombudsman found that there had been significant maladministration in two assessments carried out by the Board and that there were failings on the part of the Independent Review Panel, although the second assessment had in fact found Mrs W to be eligible for continuing health care.

The Ombudsman recommended that his report should be brought to the attention of the Independent Review Panel, to consider what further training it needed and that a retrospective assessment of Mrs W's needs should be carried out under the supervision of an independent person nominated by the Welsh Government. He also recommended that the Board should revise its procedures and conduct a retrospective review of all cases that had been handled in the same way as Mrs W's in terms of the start date for funding. Mrs S was to receive a payment of £750 and an apology for the failings.

The Ombudsman highlighted to the Welsh Government that there was a lack of appropriate guidance on these matters and it was agreed that such guidance would be introduced.

The Ombudsman decided that the case raised matters of public interest.
Case reference 201101810

Upheld

Cardiff and Vale University Health Board & Spire Cardiff Hospital – Clinical treatment in hospital
Case references 201300351 (Upheld) & 201301427 (Not Upheld) – Report issued March 2014

Mrs A complained about her surgical care and management by a Health Board Consultant for a gynaecological procedure. Mrs A had been advised she needed a specific procedure to deal with her condition. Following a number of cancellations, Mrs A's surgery was performed by the Health Board's Consultant at a private hospital in March 2008 under the then "second offer scheme" – a Welsh Government waiting list initiative whereby a patient who had planned surgery cancelled at least twice might have the procedure performed at a private hospital, but paid for by the NHS. In particular, her complaints centred on the following: the Consultant performed a different (lesser) surgical procedure on the day; and, she later suffered problems and required the original planned procedure in any event in 2012. Mrs A complained that she had eventually undergone three surgeries to deal with her problems which she felt would not have been necessary had the original planned procedure been performed. Alternatively, Mrs A said the Consultant had done something wrong. She maintained a loss of income throughout this time and said her relationship had broken down as a consequence of events. Mrs A also had concerns about the time taken by the Health Board to deal with her complaints.

In conjunction with the Ombudsman's independent clinical adviser ("the Adviser") records were examined and flaws in the consenting process and documentation highlighted. Mrs A had not been properly consented for the procedure actually performed and there was no evidence that she had been appraised of any alternative procedure which might be performed in theatre that day. However, there was no evidence to suggest that what was performed was not what the situation warranted. The Adviser commented that, for internal gynaecological conditions, a surgeon in a theatre setting is often able to "have a better look" at the patient than in an outpatient's clinic. Whilst the consent was specific to a different procedure it was likely the decision to proceed was taken with the best of intentions in that context; exposing Mrs A to a lesser surgical procedure. She had been content immediately afterwards. There was no evidence to suggest that anything untoward happened in theatre. The condition Mrs A suffered from often involved a need for further surgery, including when the more invasive operation was carried out. There was no 100% guarantee there would be no future problems. Whilst raising concerns about the consenting process and documents with the Health Board, the Ombudsman **did not uphold** the clinical complaint against either the Health Board or the private hospital.

There had been a significant delay in the Health Board's handling of Mrs A's complaint, taking a year to provide a response. This complaint was **upheld**. The Ombudsman's recommendations, as follows, were accepted by the Health Board:

a) a written apology to Mrs A for its complaint handling failure;
b) Redress for the time spent in pursuing that complaint of £500.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201204753 – Report issued March 2014
Mr A complained to the Ombudsman about the care and treatment that he received in 2009 when he attended the Emergency Unit (A&E) at the University Hospital of Wales with a wrist injury.

Mr A complained that although an X-ray confirmed he had fractured his wrist and that the damaged bone was displaced, A&E clinicians made no initial attempt to manipulate the fracture. He complained that a delay in doing so impaired his recovery and that the manipulation that was subsequently conducted set his wrist "incorrectly".

The Ombudsman did not uphold Mr A's complaint that the delay adversely impacted on his recovery, but did uphold Mr A's complaint that the manipulation resulted in the fracture healing with a degree of malunion. The Ombudsman recommended that:

a. the Health Board apologise to Mr A for a failure to identify malunion as the cause of pain and restricted movement, and for failing to take appropriate clinical measures to correct this;
b. the Health Board pay Mr A £300 in recognition of the time and trouble involved in arranging and attending additional hospital appointments and in pursuing his complaint;
c. Health Board clinicians offer to conduct a full clinical assessment of his wrist. Having done this, the Health Board should offer Mr A an appropriate payment for any loss of function;

d. following this assessment, clinicians should meet with Mr A to discuss potential further clinical interventions;

e. the Health Board reminds relevant clinicians of the importance of obtaining serial radiographs in patients who have sustained fractures until such time as the fracture has been demonstrated to have united on x-ray, particularly in the situation in which the patient is not improving as one would expect.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201204924 – Report issued March 2014
Mr M complained about the lack of Deep Vein Thrombosis (DVT – a blood clot that develops in the vein) risk assessments undertaken and venous thromboembolism (VTE) prophylaxis treatment (a preventative treatment for blood clotting) provided to his late wife, Mrs M, during her admission to a community hospital within the local area of Cardiff and Vale University Health Board. Mr M said that DVT prevention was not discussed with the family and he complained about the various explanations that had been provided by the Health Board in response to his concerns.

Having obtained professional advice on the clinical aspects of Mrs M's care, the Ombudsman **upheld** the complaint. The Ombudsman found that the relevant NICE Clinical Guidance had not been applied. Therefore, an appropriate and formal risk assessment tool for DVT was not in place at the time of Mrs M's admission. There was also no supporting documentary evidence that DVT risk assessments were undertaken or to confirm that this was discussed with the family. The Ombudsman

found that prophylaxis should have been provided to Mrs M and the Health Board had not satisfactorily explained why this did not happen. Whilst an opportunity was missed to minimise Mrs M's risk of developing a DVT, the Ombudsman was unable to conclude that if prophylaxis had been provided this would have altered the sad outcome. Finally, the Ombudsman found that much of what the family had to say during the complaints process was supported by the professional advice that she had received and this had not been acknowledged by the Health Board.

The Ombudsman recommended the following:

- an apology for the failings identified;
- a payment of £3,000 in recognition of additional distress due to the uncertainty caused to the family;
- that admission clerking proforma and medication charts include a formal DVT risk assessment tool;
- that regular audits should be carried out in relation to DVT prevention;
- that the Health Board should reflect on its complaints handling to ensure that it is sufficiently robust and independent;
- that the Health Board should remind staff of the importance of good record keeping;
- that the Health Board should consider the report as part of the Consultant Physician's next appraisal.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201301412 – Report issued February 2014
The investigation considered aspects of the management of Mrs A's pregnancy in 2010, which sadly ended in a miscarriage at 20 weeks.

The Ombudsman did not uphold Mrs A's complaint that there was no investigation of bleeding in early pregnancy. Nor did she uphold the complaint that Duphaston (a form of artificial progesterone which is no longer available in the UK, although alternatives are) tablets were not given to stop bleeding as guidance issued by the National Institute for Health and Care Excellence does not recommend the use of artificial progesterone. However, the Ombudsman found that Mrs A was not given adequate pain relief when she spent the night on a gynaecological, not an obstetric, ward, and upheld this aspect of her complaint. The Ombudsman also partly upheld a complaint that there was a delay in identifying retained placenta following the miscarriage as the Health Board did not send a discharge letter to Mrs A's GP which would have indicated the possibility of this.

The Health Board agreed to implement the following recommendations:

a) apologise fully to Mrs A for the failings identified;
b) pay Mrs A the sum of £500 to recognise the additional distress she experienced as a result of the Health Board's failings;
c) conduct an audit of obstetric discharge letters following second trimester pregnancy loss to confirm that they are routinely sent, and contain relevant information.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201203193 – Report issued February 2014

Mr A complained about the care provided for his late father, Mr B. Mr B had rheumatoid arthritis. Mr A said that the Health Board should have completed a chest X-ray, in respect of Mr B, during the twelve months that preceded his adalimumab treatment (Adalimumab blocks the inflammatory effect of tumour necrosis factor alpha [TNFα, a protein produced by the cells inside joints]; it is a major contributor to inflammation in diseases like rheumatoid arthritis, and Adalimumab treatment is a form of anti-TNFα treatment). He said that it should have referred Mr B to a cardiology specialist when it admitted him to the University Hospital of Wales. He said that it should have prescribed blood-thinning medication for him, transferred him to a specialist ward earlier and completed a CT scan of his abdomen sooner (CT - Computerised Tomography; a scan which involves scanning the body with a series of X-rays; a computer then assembles the X-rays to produce detailed images of internal structures within the body, such as organs and blood vessels). He suggested that it should have diagnosed his bowel ischaemia (insufficient supply of blood to an organ) more quickly. He said that a Consultant Surgeon ("the Surgeon") delayed his treatment unnecessarily. He suggested that the Health Board's management of Mr B's pain, after his surgery, was lacking. He was dissatisfied with the Health Board's response to his complaint because it took a long time to provide it and did not give him a copy of the Surgeon's statement.

The Ombudsman did not uphold the clinical aspects of Mr A's complaint; however, the Ombudsman did uphold the complaint handling part of it. She considered that the Health Board took too long to respond to Mr A's complaint, failed to explain this delay to him at the appropriate time and to update him. She recommended that the Health Board should:

a) apologise for the complaint handling failings identified;
b) explain to Mr A why it took so long to respond to his complaint; and,
c) send him a copy of the Surgeon's statement.

The Health Board agreed to comply with these recommendations.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201201407 – Report issued January 2014

Mrs C complained about the care provided for her late maternal grandmother, Mrs M, by Cardiff and Vale University Health Board ("the Health Board"). Her complaint concerned the Health Board's management of Mrs M's admission, ward transfer, oxygen therapy, oral care, nutrition, hydration, personal hygiene, pain and palliative care.

The Ombudsman partly upheld Mrs C's complaint. She considered that the Health Board failed to specifically assess and plan Mrs M's oral care, to record its provision consistently, to demonstrate that it confirmed the position of Mrs M's nasogastric tube ("NGT"), to investigate her ongoing breathing difficulties appropriately and to involve a Respiratory Physician in her care. She recommended that the Health Board should:

a) write to Mrs C and Mrs L, Mrs C's mother, to apologise for the failings identified;
b) share the investigation report with staff members and discuss it in an appropriate forum;
c) formally remind staff members to record the provision of oral care consistently;
d) consider introducing specific oral assessment and care planning documentation;
e) formally remind staff members to complete and record NGT positional checks;
f) formally remind staff members to complete fluid charts;
g) arrange to complete random audits of its Intentional Rounding Scheme documentation
h) introduce a care pathway for the investigation of persistent breathing difficulties with an unconfirmed diagnosis.

The Health Board agreed to comply with these recommendations.

Cardiff and Vale University Health Board – Other
Case reference 201300841 – Report issued January 2014
Mr A complained about the care and treatment his 77 year old mother ("Mrs B") received during her stay at University Hospital Wales between 5 May and 27 June 2012. Mrs B had a history of chronic obstructive pulmonary disease, atrial fibrillation, hypothyroidism, polymyalgia rheumatic and temporal arteritis. In May 2012, she was admitted to hospital with a suspected stroke. She was then diagnosed with a benign brain tumour and was an in-patient whilst waiting for surgery. Mrs B required two emergency operations for a perforated bowel that she did not have on admission. Sadly she died on 27 June. Mr A was concerned that the perforated bowel was caused by poor nursing care and by decisions taken by doctors. He complained to the Health Board, but he did not receive a reply until 8 March 2013. He said the response ignored his complaint that poor nursing care caused the perforated bowel which, he said, led to his mother's death.

The investigation found no evidence that the decisions taken by doctors, or the standard of nursing care, were direct or contributing causes of Mrs B's perforated bowel. Mrs B was at high risk of perforation due to steroid use (for a pre-existing condition) and a CT scan showed evidence of extensive diverticular disease. Therefore, I did not uphold this part of Mr A's complaint. The investigation did conclude that the Health Board's handling of his complaint was poor. I upheld this part of the complaint because the Health Board's investigation failed to consider his allegation of negligence and the time taken to respond to him was excessive.

The Health Board accepted the report and agreed to provide evidence to show that it had complied with the Ombudsman's recommendations that it should:

a) give Mr A a written apology for the failure to follow the statutory guidance when considering his complaint;
b) pay Mr A £250 for the time and trouble taken to make his complaint;

c) share the report on this investigation with all staff involved in the Health Board's consideration of his complaint, to ensure that they are aware of the need to comply with the statutory guidance;
d) formally instruct the staff involved in considering and investigating his complaint that they must ensure that, when a complaint involves an allegation of negligence or harm, the investigation, investigation report and final response must comply with statutory guidance;
e) formally instruct the nursing and clinical staff involved in this case to follow the relevant record keeping guidance;
f) give this office evidence of the systems it has put place to monitor the impact of the actions it has taken, or is taking, to address the communication failings identified by Mr A's complaint to the Health Board;
g) provide the Older People's Commissioner for Wales's report entitled: "Dignified Care?" to all staff who were involved in his mother's care when she was on the ward.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201204230 – Report issued January 2014
Mrs B complained about the standard of care provided to her late mother, Mrs A. She complained that Mrs A was inappropriately diagnosed and treated with steroids for ABPA (Allergic Bronchopulmonary Aspergillosis - a respiratory condition). She further complained about aspects of Mrs A's hospital treatment following surgery for a perforated bowel. Sadly Mrs A died following that surgery.

The Ombudsman sought clinical advice on Mrs B's complaint. As a result of that advice, it was concluded that the diagnosis and treatment of Mrs A's ABPA was appropriate. The Ombudsman did make some criticism in relation to Mrs A's antibiotic treatment, in that further blood cultures should have been taken and antibiotic therapy reviewed when she exhibited a raised temperature. She partly upheld this aspect of the complaint. The Health Board agreed to review the microbiology input into Mrs A's care and to ensure that any learning points were shared with relevant staff.

Cardiff and Vale University Health Board – Continuing Care
Case reference 201203654 – Report issued December 2013
Mrs X complained that her husband's respite care provided by the NHS was stopped inappropriately. Concern was expressed that the correct procedures had not been followed (including at Independent Review Panel [IRP] stage). Mrs X said that the assessments undertaken were not an accurate reflection of Mr X's health needs and that the eligibility criterion for NHS Funded Continuing Care (NHSFCC) had been misapplied.

It was clear that Mr X had been provided with a respite service for some years, the basis for which was not clear. He was subsequently assessed for NHSFCC in 2006 and it was decided that he was ineligible. This was not appropriately followed up or reviewed and the family continued to expect and rely upon NHS funded respite care up until early 2011 when the Health Board decided to review Mr X's circumstances under the NHSFCC arrangements.

The Ombudsman identified some shortcomings in the Health Board's application of the Welsh Government policy but overall was of the view that had this been a completely new NHSFCC assessment the decisions reached were reasonable.

However, the Ombudsman was of the view that this was not a completely new NHSFCC assessment. He found that this was not an ordinary set of circumstances and that Mr X's situation should have been considered as being of an exceptional nature.

The Ombudsman said that it was not satisfactory for the Health Board to cease providing a service in the manner that it did in 2011, after such expectation had been created. He noted that this was also within a context where there was no evidence to suggest that Mr X's needs had significantly changed.

The Ombudsman said that the Health Board should have worked more closely with Mr and Mrs X to develop a suitable and agreed plan. He was of the view that a NHSFCC assessment could have been part of this but that any reduction in NHS funded care should have been more sensitively managed and gradually introduced. The Ombudsman also expressed concern that the service was stopped inappropriately pending the Independent Review outcome and that there was no evidence that an assessment for NHS Funded Nursing care (NHSFNC) had immediately taken place although this was subsequently provided. The Ombudsman concluded that Mr and Mrs X had suffered some injustice and to the extent of the failings identified he upheld the complaint. The Health Board agreed to:

1. apologise to Mr and Mrs X for the manner in which it discontinued the provision of NHS funded respite care
2. refund the costs of respite care that Mr and Mrs X incurred whilst the recommendation by the IRP was awaited (up to December 2011)
3. refund the costs of 6 weeks care that Mr and Mrs X incurred on the basis that the Health Board should have gradually reduced its full funding of care during 2012 and 2013 (in that it would have been reasonable to have reduced to four weeks during 2012 and two weeks during 2013)
4. provide a redress payment of £500 in recognition of the poor handling of Mr X's situation and the time and trouble incurred for Mrs X in pursuing this complaint,
5. offer Mr X an up to date review of his nursing care needs.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201203441 – Report issued December 2013

Mrs T complained about the standard of renal care that her husband, Mr T, received. He had kidney failure and had been on long term dialysis. An echocardiogram in 2007 showed that he had mild aortic stenosis. In March 2012 he was referred urgently by his GP to hospital with breathlessness and atrial fibrillation. Blood tests were taken and Mr T was given aspirin and digoxin. He saw the consultant nephrologist on 4 April, but no further investigations were arranged. Mr T died on 18 April having suffered a cardiac arrest. He was found to have coronary artery disease at post mortem.

The Ombudsman sought clinical advice on the complaint. It was noted that Mr T, as a renal dialysis patient, with significant co-morbidities, was at a high risk of heart disease. The advisers felt that there were opportunities to assess the likelihood of Mr T developing critical coronary artery disease prior to 2012, but there was no specific point when further cardiac investigations were indicated. However, when Mr T was referred to the renal ward by his GP on 30 March, the care was substandard. There was no record of his attendance or his presenting symptoms. He was not properly examined or assessed nor was he referred for any further investigations. His atrial fibrillation was not treated in line with NICE guidance. Similarly his consultation on 4 April did not follow up these issues or suggest that a proper examination and assessment of his symptoms was carried out. The Ombudsman upheld the complaint.

The Ombudsman recommended that the Health Board should:

- Review the circumstances of Mr T's case, and share with relevant clinical staff, to ensure that the cardiovascular risk in renal patients is fully considered and that symptomatic patients are properly assessed. It should also review the shortcomings in record keeping concerning Mr T's 30 March hospital attendance.

- Satisfy itself that, on the relevant wards,

    a) patients presenting with Atrial Fibrillation are treated in accordance with NICE guideline 36, and;

    b) in line with GMC guidance, appropriate supervision and clear reporting structures are in place to ensure effective communication and supervision of doctors on the ward. Discharge decisions (particularly where there has been an urgent GP referral) should be made by a doctor of appropriate seniority.

- Give a full written apology to Mrs T for the shortcomings identified in this report.

- Share the content of Mr T's medical records with Mrs T and offer to meet with her, if she would find additional explanation and disclosure of Mr T's cardiac risk helpful. In addition, the Health Board should offer the possibility of screening family members to exclude familial hypercholesterolaemia (if the family would like this).

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201201480 – Report issued October 2013
Mrs A complained about inadequacies in IVF Wales' referral processes and the way that information had been communicated to her. Mrs A's health status means that she requires treatment at more highly specialised fertility treatment clinics. Mrs A highlighted that she had been placed in the position of having to repeatedly telephone and chase up IVF Wales, as well as the referral clinics, in order to progress the referrals that IVF Wales had made on her behalf.

The Ombudsman's investigation found that some of the difficulties with Mrs A's referrals were not solely down to IVF Wales. Communication issues within the referral clinics also had a bearing on the problems Mrs A encountered. That said, the investigation concluded that there were inadequacies in IVF Wales' communication process and that consequently, the referral process was not as efficient or effective as it might have been thus compromising Mrs A's clinical care. To the extent set out in the report, the Ombudsman upheld Mrs A's complaint and concluded that there were service and administrative failings.

The Ombudsman therefore made the following recommendations. Within one month of this report being finalised:

(a) the LHB's Chief Executive should apologise for the failings attributable to IVF Wales and the additional distress and inconvenience that this has caused Mrs A. In addition, in recognition of these failings the LHB should make a payment to Mrs A of £750.00.

(b) IVF Wales, under its new management structure, should continue to examine ways in which the referral process could be improved for IVF patients and report its findings to the Ombudsman's office in three months time.

(c) IVF Wales, under its new management structure, should review the mode and method for making referrals, particularly in sensitive clinical cases. If the Protocol still applies and referrals are treated as routine, it should also review whether this is appropriate and notify the Human Fertilisation and Embryology Authority of the outcome of any investigation/findings.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201202310 – Report issued October 2013

Mrs A complained about the outpatient and inpatient care provided for her late mother, Mrs B, by Cardiff and Vale University Health Board ("the Health Board"). Mrs B had respiratory problems. Mrs A said that Mrs B's Consultant should have investigated her condition further and referred her to the nebuliser clinic. She suggested that the nursing care that Mrs B received, as an inpatient, was lacking because she sustained an unexplained head injury during her hospital admission. She also expressed concern about Mrs B's sedation and her ward transfer following her death. She was dissatisfied with the Health Board's response to her complaint.

The Ombudsman upheld Mrs A's complaint. He considered that the Health Board took too long to complete Mrs B's nebuliser assessment and to investigate her condition following a scan. He concluded that the Health Board's management of Mrs B's ward transfer and her falls risk was poor. However, he could not determine that Mrs B's head injury occurred because of any failings by the Health Board. He recommended that the Health Board should:

(a) Write to Mrs A to apologise for the failings identified.
(b) Review its arrangements for nebuliser assessments and ensure that it is able to provide them, on a routine basis, within three months of their request.

(c) Formally remind relevant clinicians that they should not discharge patients from their care when these patients are awaiting the outcome of significant investigations, which they have requested.
(d) Formally remind relevant nursing staff members that they should complete falls risk assessments fully and in accordance with the relevant guidelines.
(e) Share his investigation report with all relevant staff members.

The Health Board agreed to comply with these recommendations.

August 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mrs V had a rare neuro-endocrine disorder called Hashimotos Encephalitis ("HE") which affected her capacity to make decisions. In 2011 Mrs V was diagnosed with Acute Myloid Leukemia ("AML"). Having successfully undertaken the first cycle of chemotherapy, Mrs V refused to have any additional treatment or accept any care provided by the hospital. Mr V complained that the doctors caring for his late wife failed to adequately test her capacity to make decisions relating to treatment and care. This element of the complaint was upheld, the evidence showed that only one formal mental capacity test had been undertaken.

Mr V expressed concern about the nursing staff decision to refer what they believed to be his "controlling" behaviour to POVA. Mr V said that he had supported the decision to discharge Mrs V following her initial cycle of chemotherapy, but he wanted to be sure that an appropriate care package was in place. This element of the complaint was not upheld and the nurses' actions were reasonable given their legitimate concerns about Mr V's behaviour.

It was recommended that the Health Board apologise to Mr V for the service failure identified and pay £250 in recognition of the time and trouble in bringing his complaint to this office. It was also recommended that the Health Board remind relevant staff of the need to complete the mental capacity forms when testing a patient's capacity to make complex or major decisions and monitor their use. Finally, it was recommended that the Health Board include training on mental capacity and consent to treatment in its rolling programme of training and ensure information is available to all staff.

Case reference 201201552

August 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mrs M's complaint concerned the management of her late father Mr A's dietary/fluid intake whilst an inpatient in the University of Wales Hospital ("the Hospital") between 18 January and 12 February 2012. She also expressed concerns that a Do Not Attempt Resuscitation ("DNAR") order was in place in January but only discussed with the family on 12 February 2012.

The Ombudsman's investigation concluded that the DNAR decision contained in Mr A's records was not completed accurately and that his medical records did not contain records of any discussions which might have taken place with Mr A's family. The Ombudsman was concerned that, despite knowing that Mr A had dementia and that there was a potential issue with capacity, this was not considered and

appropriate advice was not taken. Whilst he recognised that the DNAR decision rests with the treating clinician, he was critical that the guidance was not followed and Mrs M's complaint was upheld.

In relation to the nursing care, the investigation found that there were appropriate assessments of Mr A's nutritional needs and that attempts were made to meet Mr A's nutritional needs. However, he found shortcomings in the care Mr A received during his last days in the Hospital which included an apparent lack of person centred care planning and a poor engagement with Mr A's family. Mrs M's complaint was upheld limited to that extent.

In relation to the Health Board's handling of Mrs M's complaint, the Ombudsman was not convinced that the response provided to her concerning the DNAR was sufficiently accurate, thorough or transparent in light of what the investigation has uncovered and therefore upheld Mrs M's complaint.

The Ombudsman made a number of recommendations, including:

- the Health Board was asked to apologise to Mrs M and for failings in the care provided to her father and in recognition of the shortcomings in the Health Board's complaints handling the Health Board was asked to make a payment of £500 to Mrs M;
- the Health Board was asked to provide training to its responsible senior clinical staff who have authority to make DNAR orders on the national guidelines and the legal implications of non compliance with guidance. Staff should also be reminded of the procedure for completing DNAR forms.

Case reference 201202178

June 2013 – Other – Cardiff and Vale University Health Board

Mr C complained about the care given to his daughter, Ms C, by Cardiff and Vale University LHB ("the first LHB"). In January 2009, Ms C was diagnosed with Acute Lymphoblastic Leukaemia. Her care was managed by the University Hospital of Wales as part of the UKALL 2003 trial ("the trial"). Due to the distance between Ms C's home and the University Hospital of Wales, the first LHB adopted a shared care arrangement with a second LHB. Mr C said that the second LHB advised Ms C that she should only receive irradiated blood products. Sadly, MS C died in August 2010. Mr C later obtained a copy of her medical records, these noted that the first LHB had given Ms C blood products that were not irradiated. Mr C said that he thought this compromised her remission. He also complained that the first LHB had not responded to his complaints about the matter in a timely manner.

The investigation considered the information provided by Mr C, the LHBs and the relevant statutory guidance on NHS complaint handling. I obtained professional advice from an experienced Consultant Haematologist ("the Adviser") who said that the trial did not specify the use of irradiated blood products. The Adviser said that Ms C's medical situation did not require the use of irradiated blood components and that she could safely have received either irradiated or un-irradiated blood products. The investigation found no evidence to suggest that there was a failing in the care given to Ms C by the first LHB; therefore I did not uphold this part of the complaint. The investigation did identify serious delays in the first LHB's handling of the

complaint and I upheld this part of the complaint. Importantly, the investigation did identify a lack of formal shared care arrangements. I considered this was inappropriate as the absence of formal arrangements contributed to Mr C's belief that Ms C should only receive irradiated blood products. The first LHB agreed to implement my recommendations which included the requirement to implement a policy on managing shared care arrangements; an apology for the failure to comply with relevant Guidance when responding to Mr C's complaints and a payment to him of £500, to reflect the distress the delays in dealing with his complaint caused and the time and trouble taken in making his complaint.

Case reference 201202235

June 2013 – Other – Cardiff and Vale University Health Board

Mrs E complained that the LHB failed to diagnose problems with her hips whilst she was under the care of the Movement Disorder Clinic ("the MDC") at the University Hospital of Wales following a diagnosis of spastic paraparesis with peripheral neuropathy. She said that, in September 2011, she was advised by a private orthopaedic consultant that she needed both hips replaced. She said the private orthopaedic consultant told her she would have to wait up to a year for NHS surgery, so she paid privately to have her left hip replaced. She said that if the LHB had diagnosed the problems sooner she would not have had to fund the treatment herself. She said that the NHS should reimburse the costs involved.

I considered the Welsh Government's "Rules for Managing Referral to Treatment Waiting Times" and "Putting Things Right" the statutory guidance on NHS complaint handling ("PTR"). I also obtained professional advice from an experienced Consultant Neurologist. He said that he could not see evidence that the response of any of the NHS clinicians involved was unduly tardy or displayed any lack of clinical care or skill. The investigation identified that, on several occasions, Mrs E had the option to be treated by the NHS; however, each time, she chose to be treated in the private sector.

The investigation concluded that there was no failing in the care provided by the LHB. I did not uphold this part of the complaint or recommend that the NHS should reimburse Mrs E. The investigation did identify serious delays in the LHB's handling of the complaint. I upheld this part of the complaint. The LHB agreed to implement my recommendations which included an apology and a payment to Mrs E of £100 for the time and trouble taken to make her complaint.

Case reference 201202988

May 2013 – Continuing Care – Cardiff and Vale University Health Board & Powys Teaching Health Board

Mr E believed that the care home fees for his late wife's care in 1998 should have been met by the NHS under Continuing Healthcare (CHC) funding. He followed the process to claim back such costs and the decision was made that his wife was been eligible for funding in 1998. However, no reimbursement has been made to Mr E because the Health Boards told him that there was insufficient proof that he or his late wife had paid the fees.

The aim of retrospective CHC funding is to rectify previous maladministration where some patients have wrongly had to fund their own nursing home care. Claims have

to be seen in this context. For older claims, it is often difficult to provide full documentary evidence (such as bank statements, invoices etc) for all monies paid because these documents may no longer be available. This can put these claimants at a disadvantage.

The Ombudsman found maladministration and upheld Mr E's complaint. It was unreasonable for the Health Board to keep asking for proof of payment which it knew did not exist. Both Health Boards could have highlighted the deficiency in Mr E's proof of payment evidence at a much earlier date (when he would have had an opportunity to get additional evidence). Finally, the evidence from both Health Boards indicated that a coherent and consistent approach to the issue of proof of payment (in retrospective cases) was lacking.

The Ombudsman recommended that the Health Boards should:

- Reimburse Mrs E's care home fees, with appropriate interest,
- Apologise to Mr E for the additional delay and frustration caused by the Health Boards' handling of his case,
- Be involved in discussion to ensure that there was a fair and consistent approach when considering proof of payment, in particular for older retrospective cases.

Case reference 201201957 & 201300028

May 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mrs P complained that she was unfairly treated because she made a complaint about the care and treatment provided to her at a fertility clinic ("the fertility clinic") within the local area of Cardiff & Vale University LHB. Mrs P said that the consultant ended the professional relationship because of her complaint. Mrs P also raised concerns about the medication provided to her and about the delay in receiving a complaints response.

Having obtained professional advice, the Ombudsman partly upheld the complaint. The Ombudsman found that the timing and way in which the consultant ended the professional relationship was inappropriate. However, the Ombudsman was unable to conclude that the consultant ought not to have ended the relationship. The Ombudsman found that the use of medication was appropriate and that the delay in receiving a complaints response was because additional time was required to complete the response. The evidence confirmed that the Health Board had provided Mrs P with regular updates during this time and had apologised for the time taken when the final response issued.

The Ombudsman recommended that the Health Board should:

1. Provide an apology for the failings identified;
2. Make a payment of £500 in respect of additional distress and confusion caused;
3. Develop a suitable protocol for offering a second opinion in situations where either the couple or doctor is uncomfortable with continuing with the professional relationship.

Case reference 201202520

Not Upheld

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201300819 – Report issued January 2014
Mrs P complained to the Ombudsman about the treatment her late husband received at Llandough and University of Wales hospitals. She complained about a number of issues including that the Health Board unreasonably delayed a procedure to provide him with a percutaneous endoscopic gastrostomy (PEG) tube; that the Health Board did not investigate the cause of his respiratory infection appropriately and that it had concentrated its efforts incorrectly on Motor Neurone disease instead of considering the possibility that he had contracted a tropical disease whilst travelling abroad.

The Ombudsman found that the treatment her husband had received had been appropriate and that the correct investigations, including the possibility of the involvement of tropical diseases as underlying cause had been considered and investigated. Mr P did not receive the PEG for clinical reasons related to his condition at the time he was being assessed for the procedure. Whilst shortcomings in communicating the reasons for postponing the PEG procedure were acknowledged and apologised for by the Health Board, the rationale for doing so was found to be sound. Accordingly the Ombudsman did not uphold the complaint.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201301877 – Report issued December 2013
Mrs D complained about the treatment she received following an injury to her shoulder. She complained that there was a delay in referring her from the Accident & Emergency Department to a suitable specialist. She said that this delay caused her to suffer additional pain and also affected her long-term recovery. She also complained that either her initial diagnosis was wrong or that her injury worsened whilst she awaited a specialist appointment.

The Ombudsman found that the treatment Mrs D received was in line with recognised practice and that the short delay in her seeing a specialist was neither unreasonable nor clinically significant in terms of her overall recovery. The Ombudsman did not uphold the complaint.

Cardiff and Vale University Health Board & Welsh Ambulance Services NHS Trust – Clinical treatment in hospital
Case references 201203928 & 201205014 – Reports issued November 2013
Mr G complained about his mother's care (Mrs W) and management in what were her final days. He had a number of complaints, including as follows against the Health Board: a District Nurse (DN) had without his consent administered Mrs W with Hyoscine[2] (when he was not present) and Mrs W had suffered a fit necessitating her admission to hospital; Mrs W was moved overnight to a ward so that he did not know where she was the next morning and staff were initially unable to tell him; he was asked to leave the ward on arrival and told his mother was stable; and having gone

[2] Hyoscine is a drug given in palliative care to dry up noisy chest secretions that can be distressing for both patient and relatives

home he was denied the opportunity of being with Mrs W when she passed away a short while later.

As against WAST, he complained that there was a delay in an ambulance attending to convey Mrs W to hospital and the journey was uncomfortable.

The investigation did not uphold the complaints against the Health Board**.** The Ombudsman's professional advisers confirmed that here was no failure in Mrs W's clinical care. The DN was entitled to administer the drug (already prescribed by Mrs W's GP) in Mrs W's best interests given her condition at the time, without any consent; moreover her daughter (Mr G's sister) was present and had agreed. There was nothing to suggest that the drug had adversely affected Mrs W; she was very ill and on a palliative care regime. As Mr G arrived the following morning when staff were changing shifts, they had not completed a handover to know which patients had been moved to a ward overnight. Other ladies were about to undergo their morning wash, so for dignity reasons it was not unreasonable to ask Mr G to temporarily leave the ward area. At the time, whilst appreciating Mrs W was gravely ill, it was not unreasonable either to describe her condition as stable, in the context of how she had been on admission. Her sudden deterioration before Mr G's return could not have been predicted, but the Ombudsman acknowledged the evident distress not being with his mother had caused Mr G.

The **WAST** acknowledged that whilst an initial responder had attended Mrs W in good time, there had been a failure to check vehicle availability with every control centre so that an ambulance (believed not to have been available) could have been despatched to arrive some 20 minutes or so sooner than it did. This aspect of Mr G's complaint was **upheld**. The WAST apologised and confirmed instructions had been issued Wales wide to avoid a recurrence. The Ombudsman's clinical advisers confirmed that the 20 minutes would not have affected the management of Mrs W, or the sad outcome. The complaint about the journey could be taken no further than an examination of the vehicle's service records, which found it to have been regularly maintained and fully serviced, and so was **not upheld**.

August 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mrs A complained about the care and treatment provided to her by the Health Board, specifically in relation to the problems she experienced as a result of abdominal hernia repairs with surgical mesh and abdominal wounds which would not heal. She complained that surgery planned for December 2010 was only undertaken in February 2011 because of four cancelled operations. She also complained that surgical staples had been used during an operation in June 2009 when she had told staff that she was allergic to them.

The investigation found that the care and treatment provided to Mrs A had not fallen below a reasonable standard. She was reviewed regularly and appropriate action was taken, including surgery, when necessary. The Health Board could not be criticised for the unfortunate cancellations of her surgery in late 2010/early 2011. While the surgical staples used would have been made of low or non-allergenic material, the Health Board accepted that her allergy should have been recorded and it apologised for not doing that. The complaint was therefore **not upheld**.

Case reference 201201863

April 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mr X complained about aspects of the care of his late wife at Llandough Hospital. Mrs X was frail with a complex clinical history. On 1 February 2012 a pleural aspirate (a procedure to take a sample of lung fluid) was undertaken by a junior doctor under the supervision of a Respiratory Registrar. The Health Board said that the pleural aspiration was to rule out infection of lung fluid, cancer or other conditions. The Registrar took verbal consent from Mrs X for the procedure. Mrs X subsequently suffered a collapsed lung, a known complication of pleural aspiration, for which she required emergency treatment.

Mr X complained about the need for the pleural aspirate, and that appropriate consent was not obtained for the procedure. Mr X believed that as his wife was frail, disorientated, hallucinating and very frightened, the Registrar should have involved Mr X in the decision for the pleural aspirate. Mr X's view was that procedure was not in his wife's best interests given the risks involved.

The Ombudsman did not uphold Mr X's complaints. Taking account of independent professional advice, he found that there was a sound clinical basis for the pleural aspirate. There was insufficient evidence to conclude that Mrs X was confused at the time she gave her consent, although given her frailties it would have been better for the Registrar to have spoken to Mr X about the procedure. However, the Registrar had not acted unreasonably.

Case reference 201202302

April 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mrs H complained about the care and treatment that she received in the University Hospital of Wales, when she gave birth to her baby in February 2012. Mrs H said that the labour was prolonged, and the delivery was distressful. Mrs H complained that the treatment was such that it caused the fracture of the right hand side of her baby's skull. The Health Board carried out its initial investigation into the complaint, but Mrs H remained dissatisfied with the response and therefore wrote a further letter to the Health Board to ask that it consider whether or not there was a qualifying on its part in accordance with the regulations known as the "Putting Things Right" scheme. Mrs H complained to the Ombudsman that she had not received a response 5 months later.

Upon receiving the complaint, the Investigating Officer considered that it was appropriate for the Health Board to provide its further response to Mrs H, given her request that the Health Board confirm its position in relation to a qualifying liability. The Health Board agreed to provide Mrs H with a written response within 14 working days.

Case reference 201205115

April 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mr A's complaint to the Ombudsman concerned the clinical care and treatment provided to his late mother whilst an inpatient in the University of Wales Hospital. An investigation was started and Mr A's mother's medical records were requested from the Health Board ("the HB"). The HB was unable to provide the medical records as it said they had been mislaid. This was of great concern to the Ombudsman. The Ombudsman concluded that the HB's loss of the records was maladministrative and caused Mr A injustice, as without the medical records, the Ombudsman was unable to carry out a meaningful investigation to the complaint Mr A had raised. Consequently, Mr A had been denied an opportunity to have an independent review of his complaint by the Ombudsman.

The Health Board agreed to the following settlement proposals:

1. Within one month of the settlement letter being issued the Chief Executive would apologise in writing to Mr A for the injustice caused to him by not being able to have his complaint reviewed by the Ombudsman and would make a payment to him of £1750.

2. For a period of 12 months the Health Board would continue to actively search for the medical records and update this office on a quarterly basis with a copy to Mr A, explaining the actions it had taken to locate the records.

3. Within two months of the settlement letter being issued, if it had not already done so, the Health Board should carry out a root cause analysis of the loss of the records as part of its information security policy and report its findings to this office.

4. The Health Board as part of its internal review of the complaint identified shortcomings in the handling of Mr A's mother's care. However, the Ombudsman found it disappointing that these had not been taken further. The Health Board agreed that within two months of the settlement letter being issued it would provide documentary evidence on how it had addressed those issues. These included:

    - Lack of continuity of care – internal ward transfers and no continuous visible consultant responsibility.
    - Junior doctors shying away from specifically describing the high probability of death in complex elderly cases in unambiguous terms and at the same time recording this in the notes.
    - Regular communications with patients/relatives and "ceiling of care" decisions to be recorded in the notes.
    - Following the initial bereavement meeting if a complainant remained dissatisfied, arranging for further meetings to be conducted by an uninvolved consultant colleague.

Case reference 201202167

Quick fixes and Voluntary Settlements

Cardiff and Vale University Health Board – Rudeness/inconsiderate behaviour/staff attitude
Case reference 201306235 – March 2014
The complainant, Mrs B, was unhappy with the treatment and care her late mother received whilst at Hospital during June 2013.

The investigation revealed that Mrs B had inadvertently forgotten to respond to a letter from the Health Board sent in December 2013 offering her a meeting with the Investigating Officer to discuss outstanding matters.

The Ombudsman contacted the Health Board who agreed to offer a further opportunity to meet and it was agreed that this should take place on 3 April 2014.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201305263 – February 2014
On 3 July 2013, Ms E complained to the Health Board about the care and treatment that she received from Gabalfa Clinic. The Health Board provided its response to the complaint on 28 August 2013, but Ms E remained dissatisfied. In November 2013, Ms E complained to the Ombudsman that the Health Board had failed to respond to her concerns. Having considered the complaint, the Ombudsman was not satisfied that the complaint had been properly addressed, therefore the Health Board were asked to provide a further response. The Health Board did so on 3 December 2013, but Ms E remained dissatisfied on the basis that the further response still failed to respond to all of the concerns raised.

It was suggested that the Health Board arrange a meeting with Ms E to discuss the outstanding concerns relating to maintaining confidentiality of the Emotional Regulation Group (ERG); Concerns about comments made during the ERG; Group composition; and, the lack of contact from Gabalfa Clinic.

Cardiff and Vale University Health Board – Continuing care
Case reference 201304919 – January 2014
Mr G's solicitors complained about the Health Board's consideration of a retrospective application for funding for the care home fees of Mr G's late mother. Mr G's solicitors said that the Health Board had failed to act in accordance with procedure, had not taken into account all relevant information in reaching a decision on eligibility and had unreasonably declined to refer the case to an independent panel.

The Ombudsman contacted the Health Board to commence an investigation, but asked if a settlement might be reached in the alternative. In response, the Health Board agreed to reconsider the case, taking into account all of the concerns raised by Mr G's solicitors, and to issue a fresh decision, ensuring that comprehensive reasoning was provided. The Ombudsman considered this to be a fair resolution. The Ombudsman therefore discontinued her investigation on the basis of this voluntary settlement.

Cardiff and Vale University Health Board – Other
Case reference 201304396 – December 2013
Mrs A and family made a donation for a memorial bench to be placed; the donation was intended to extend their heartfelt appreciation for the care and treatment afforded to a family member. After several months, Mrs A complained that, whilst the funds had cleared, the bench had yet to be located. The Ombudsman's office contacted the Health Board, who agreed to write to Mrs A and expedite the placement of the bench.

Cardiff and Vale University Health Board – Continuing care
Case reference 201300276 – December 2013
Mr S complained that the Health Board had refused to reimburse care home fees for the late Mrs B, for the entire period she had been subsequently assessed as eligible. Following a retrospective review for NHS funded Continuing Care (the payment by the NHS of care fees for those found to have continuing and complex health care needs), Mrs B was found eligible for the period February 2001 – April 2004. However, the Heath Board refused to reimburse Mr S the full costs of her care.

During that period Mrs B had been resident in two different care homes. The first care home (to March 2002) no longer existed. The Health Board was satisfied about her period at the second care home, which still existed. The only evidence Mr S could supply comprised of copy cheque stubs for an account for Mrs B (completed with the first care home as payee), and copy bank statements showing those cheques as cleared for similar sums monthly through that account. Additionally, he provided a letter from her local Council confirming that Mrs B had self funded care services provided to her in the community before being admitted to residential care. The Health Board said that Mr S's evidence was insufficient.

The investigation considered Mr S's evidence and all relevant guidance on NHS funded Continuing Care matters. The Ombudsman approached the Health Board on the basis that, in view of the evidence and the particular circumstances of the case, its stance appeared unreasonable. The Health Board agreed to settle the complaint, reimbursing Mr S the full fees (a total of £66,810). The Ombudsman felt this to be a reasonable settlement and discontinued the investigation on this basis.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201303232 – November 2013
Ms E complained to the Health Board about the care and treatment that she received. Ms E said that she had received the Health Board's response to her complaint, but she was not satisfied that it had carried out a thorough investigation into her concerns. Ms E said that the Health Board had placed too much reliance on an earlier Health and Care Professions Council (HCPC) decision, following its consideration of a registered professional's fitness to practice.

Following consideration of the complaint, the Ombudsman saw no evidence to suggest that the matters which had originally been considered by the HCPC were the same as that which had been referred to the Health Board. The Health Board was contacted and asked to provide Ms E with a full written response to her complaint. The Health Board agreed to do so within 20 working days.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201302970 – November 2013
Ms G complained about a number of aspects of her care by the Health Board's mental health services. After the Ombudsman started an investigation, the Health Board offered Ms G a meeting to discuss, and hopefully resolve, her outstanding concerns. Ms G accepted the Health Board's offer, and the investigation was discontinued on that basis.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201303887 – October 2013
Mrs X contacted the Ombudsman after waiting over 6 months for a response to her complaint surrounding her mother's treatment at a hospital in the Health Board's area. The Ombudsman's office contacted the Health Board, which agreed to provide a response by a specified date.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201303417 – October 2013
Mrs R complained that she had not heard from the Health Board since a meeting she had attended to discuss her complaint. The Ombudsman's office contacted the Health Board, which advised that a response had not been issued because the relevant member of staff had been on leave. However, the member of staff was now in a position to consider the matter and a response would be issued shortly

September 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Ms D complained about the standard of care that she received at Llandough Hospital following her initial breast surgery in October 2010, which led to further admissions and treatment in March 2011. Upon receipt of the Health Board's response to her complaint, Ms D complained that there were a number of outstanding concerns which had not been addressed in the response, and she therefore sought further clarity.

Following consideration of the complaint, it was noted that whilst the Health Board had provided a written response to the initial complaint, it would be helpful to Ms D if the Health Board could provide further clarification in relation to the outstanding concerns. The Health Board agreed to provide Ms D with a further written response within 30 working days.
Case reference 201302958

April 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mrs H complained about the care and treatment that she received in the University Hospital of Wales, when she gave birth to her baby in February 2012. Mrs H said that the labour was prolonged, and the delivery was distressing. Mrs H complained that the treatment was such that it caused the fracture of the right hand side of her baby's skull. The Health Board carried out its initial investigation into the complaint, but Mrs H remained dissatisfied with the response and therefore wrote a further letter to the Health Board to ask that it consider whether or not there was a qualifying liability on its part in accordance with "Putting Things Right". Mrs H complained to the Ombudsman that she had not received a response 5 months later.

Upon receiving the complaint, the Investigating Officer considered that it was appropriate for the Health Board to provide its further response to Mrs H, given her request that the Health Board confirm its position in relation to a qualifying liability. The Health Board agreed to provide Mrs H with a written response within 14 working days.

Case reference 201205115

April 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mr A's complaint to the Ombudsman concerned the clinical care and treatment provided to his late mother whilst an inpatient in the University of Wales Hospital. An investigation was started and Mr A's mother's medical records were requested from the Health Board ("the HB"). The HB was unable to provide the medical records as it said they had been mislaid. This was of great concern to the Ombudsman.

The Ombudsman concluded that the HB's loss of the records was maladministrative and caused Mr A injustice, as without the medical records, the Ombudsman was unable to carry out a meaningful investigation to the complaint Mr A had raised. Consequently, Mr A had been denied an opportunity to have an independent review of his complaint by the Ombudsman.

The Health Board agreed to the following settlement proposals:

a. within one month of the settlement letter being issued the Chief Executive would apologise in writing to Mr A for the injustice caused to him by not being able to have his complaint reviewed by the Ombudsman and would make a payment to him of £1750;
b. for a period of 12 months the Health Board would continue to actively search for the medical records and update this office on a quarterly basis with a copy to Mr A, explaining the actions it had taken to locate the records;
c. within two months of the settlement letter being issued, if it had not already done so, the Health Board should carry out a root cause analysis of the loss of the records as part of its information security policy and report its findings to this office;
d. the Health Board as part of its internal review of the complaint identified shortcomings in the handling of Mr A's mother's care. However, the Ombudsman found it disappointing that these had not been taken further.

The Health Board agreed that within two months of the settlement letter being issued it would provide documentary evidence on how it had addressed those issues. These included:

- lack of continuity of care – internal ward transfers and no continuous visible consultant responsibility;
- junior doctors shying away from specifically describing the high probability of death in complex cases involving older people in unambiguous terms and at the same time recording this in the notes;
- regular communications with patients/relatives and "ceiling of care" decisions to be recorded in the notes;

- following the initial bereavement meeting if a complainant remained dissatisfied, arranging for further meetings to be conducted by an uninvolved consultant colleague.

Case reference 201202167