Our ref: PT/jm
Ask for: James Merrifield

Your ref:
01656 644 200

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

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

Annual Letter 2012-2013

Following the recent publication of my Annual Report, I am pleased to provide you with the Annual Letter (2012-2013) for Cardiff and Vale University Health Board.

As outlined in my Annual Report, the number of new complaints to my office increased by 12% compared with 2011/12. Health complaints continue to be the most numerous type of complaint and now account for more than a third of all complaints received. Whilst some of the increase can be attributed to changes brought about under the Putting Things Right redress arrangements, the increase almost certainly reflects a greater dissatisfaction with the health service.

In reference to the overall performance of Health Boards in Wales, there has been a 35% increase in the number of investigation reports issued by my office during 2012/13 compared with 2011/12. I have also again had cause to issue a number of Public Interest Reports identifying serious concerns and failings, all of which have concerned health bodies. Whilst the average number of 'not upheld' reports issued against health bodies has remained the same as last year, I am disappointed to note such a large increase in the average number of 'upheld' reports from 11 to 21 reports.

It is worth noting a further year-on-year increase in the levels of 'Quick Fixes' and 'Voluntary Settlements' achieved by this office, from 13 to 16 cases. In order to maximise the opportunities to learn lessons from these types of cases, you can now find the summaries of quick fixes and voluntary settlements included in my quarterly publication, The Ombudsman's Casebook.

However, I am disappointed to note that the amount of time taken by public bodies in Wales in responding to requests for information from my office has not improved. I am concerned that 45% of all responses took longer than five weeks, with 28% of responses taking in excess of 6 weeks. Whilst I appreciate that resources are stretched at this time, such delays obstruct me from providing complainants with the level of service which they should rightly expect to receive and I urge all Welsh public bodies to review their performance.

In reference to your Health Board, there has been a noticeable increase in the numbers of complaints received and investigated, compared with 2011/12. These figures are also above the health body averages. As with 2011/12, the largest area of complaint remains 'clinical treatment in hospital', whilst there has also been an increase in the number of complaints relating to 'Continuing care'. It is pleasing to note the large increase in the number of quick fixes and voluntary settlements, which are above the health body average. However, it should also be noted that there has been an increase in the number of 'upheld' reports issued by my office, which is also above the average. It is pleasing to note that responses from your Health Board were generally provided more quickly that the 'Health body' and 'All Wales' averages.

As with previous exercises, I have copied this correspondence to the Chair of your Health Board with the intention that it be considered by the Board. I would also welcome the opportunity to meet and my office will be in contact shortly to make the necessary arrangements. Finally, a copy of this letter will be published on my website.

Yours sincerely

Peter Tyndall
Ombudsman

Copy: Chair, 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 2012-2013 with the average for health bodies (adjusted for population distribution[1]) during the same period.

Section B provides a breakdown of the number of complaints received by my office, broken down into subject categories.

Section C compares the number of complaints against the Health Board received by my office during 2012-2013, with the average for health bodies during this period. The figures are broken down into subject categories.

Section D provides the number of complaints against the Health Board which were taken into investigation by my office in 2012-2013.

Section E compares the number of complaints against the Health Board which were taken into investigation by my office in 2012-2013, with the average for health bodies (adjusted for population distribution) during the same period.

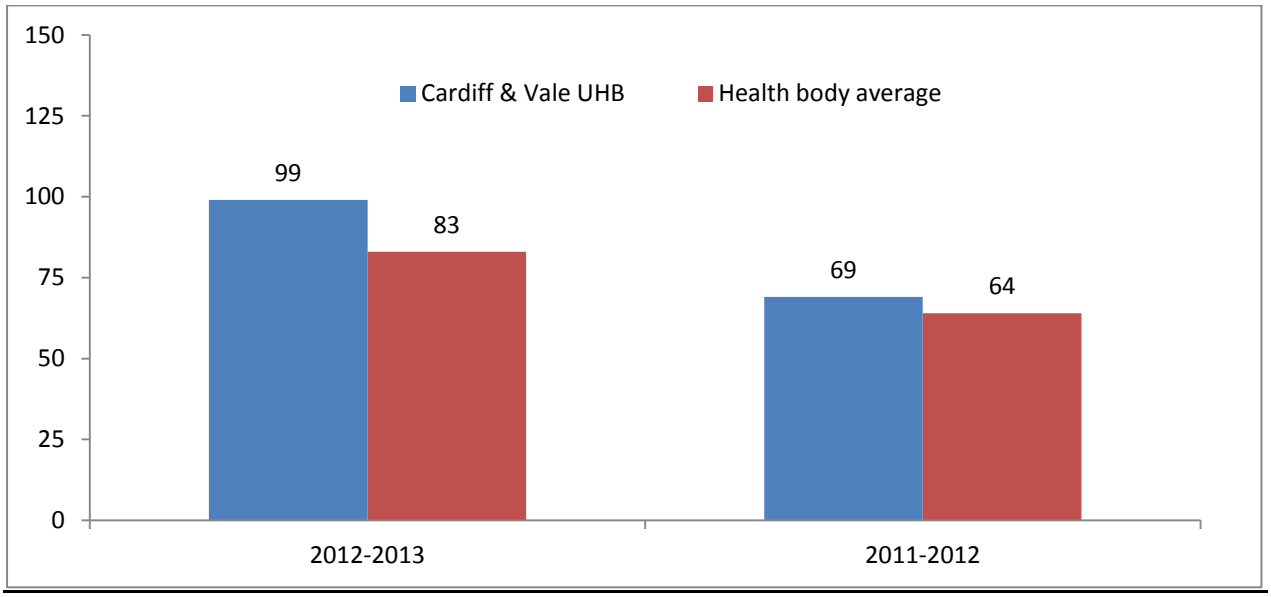
Section F compares the complaint outcomes for the Health Board during 2012-2013, with the average outcome for health bodies during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section G compares the Health Board's response times during 2012-2013, with the average response times for health bodies, and the average for all public bodies in Wales during the same period. This graph measures the time between the date my office issued an 'investigation commencement' letter, and the date my office receives a full response to that letter from the public body.

Finally, Section H contains the summaries of all reports issued in relation to the Health Board during 2012-2013.

[1] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039

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

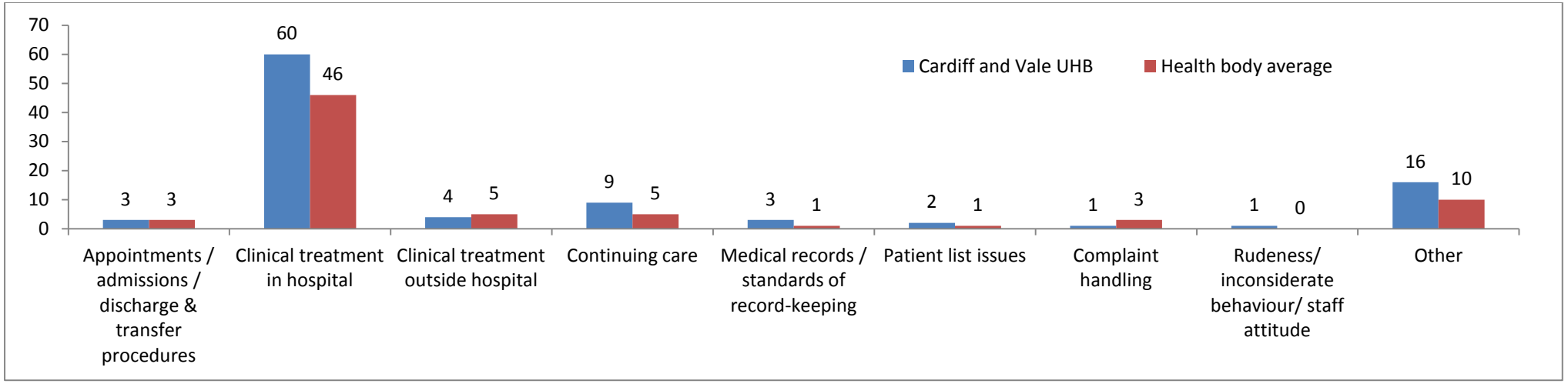


B: Complaints received by my office

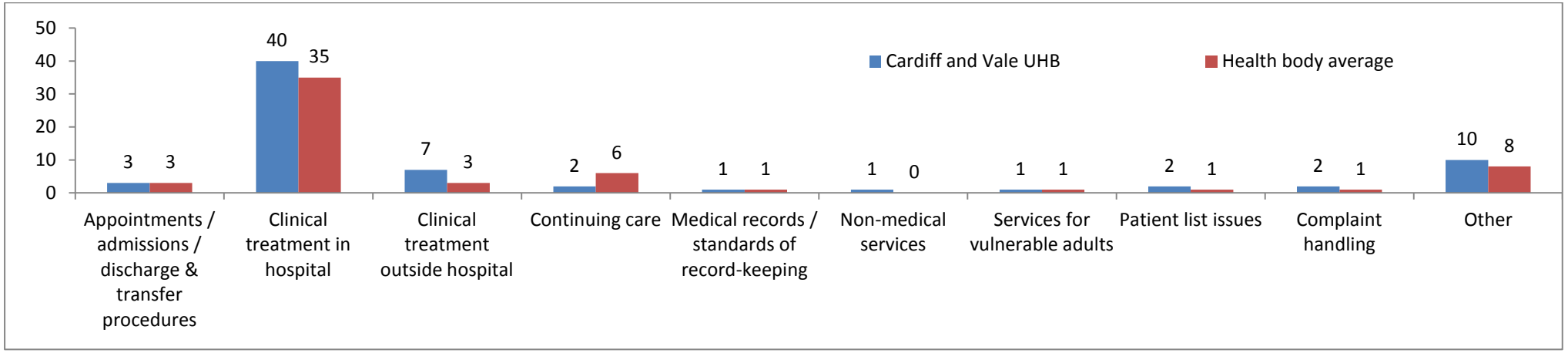
Subject	2012-2013	2011-2012
Appointments/ Admissions/ Discharge and transfer procedures	3	3
Clinical treatment in hospital	60	40
Clinical treatment outside hospital	4	7
Continuing care	9	2
Medical records/ standards of record-keeping	3	1
Non-medical services	0	1
Services for vulnerable adults	0	1
Patient list issues	2	2
Complaint-handling	1	2
Rudeness / inconsiderate behaviour / staff attitude	1	0
Other	16	10
TOTAL	**99**	**69**

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

2012-2013



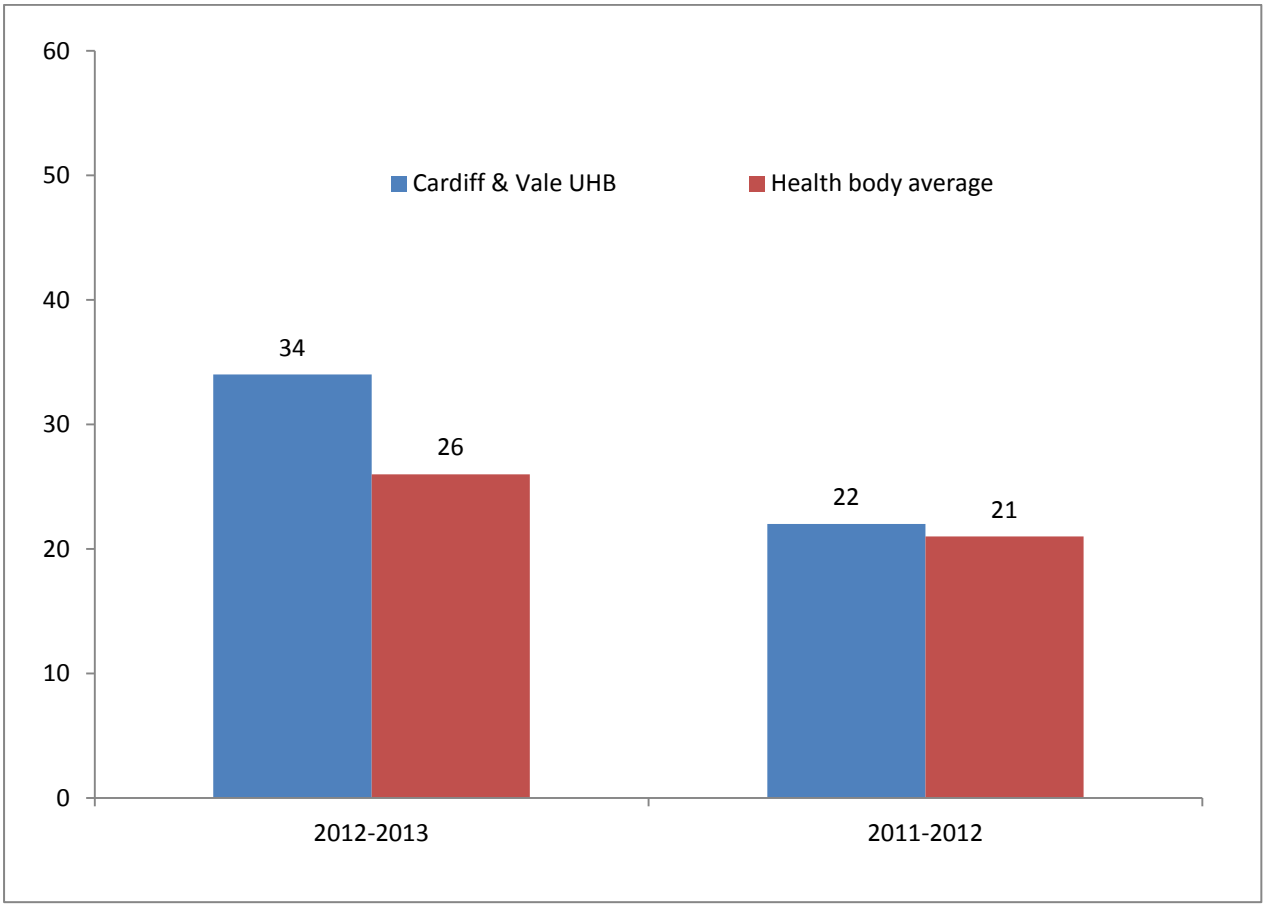
2011-2012



D: Complaints taken into investigation by my office

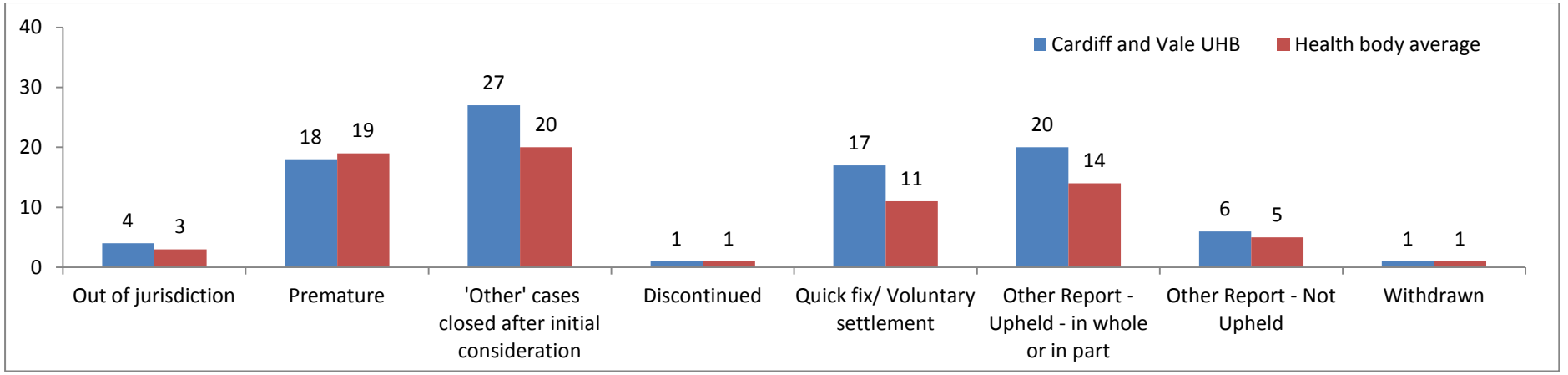
	2012-2013	2011-2012
Number of complaints taken into investigation	34	22

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

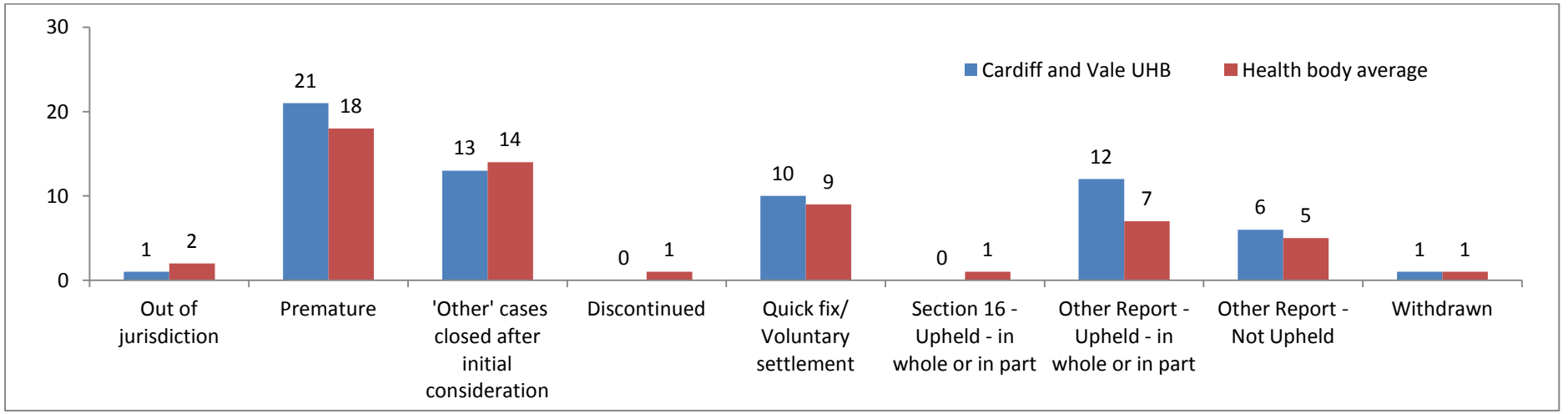


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

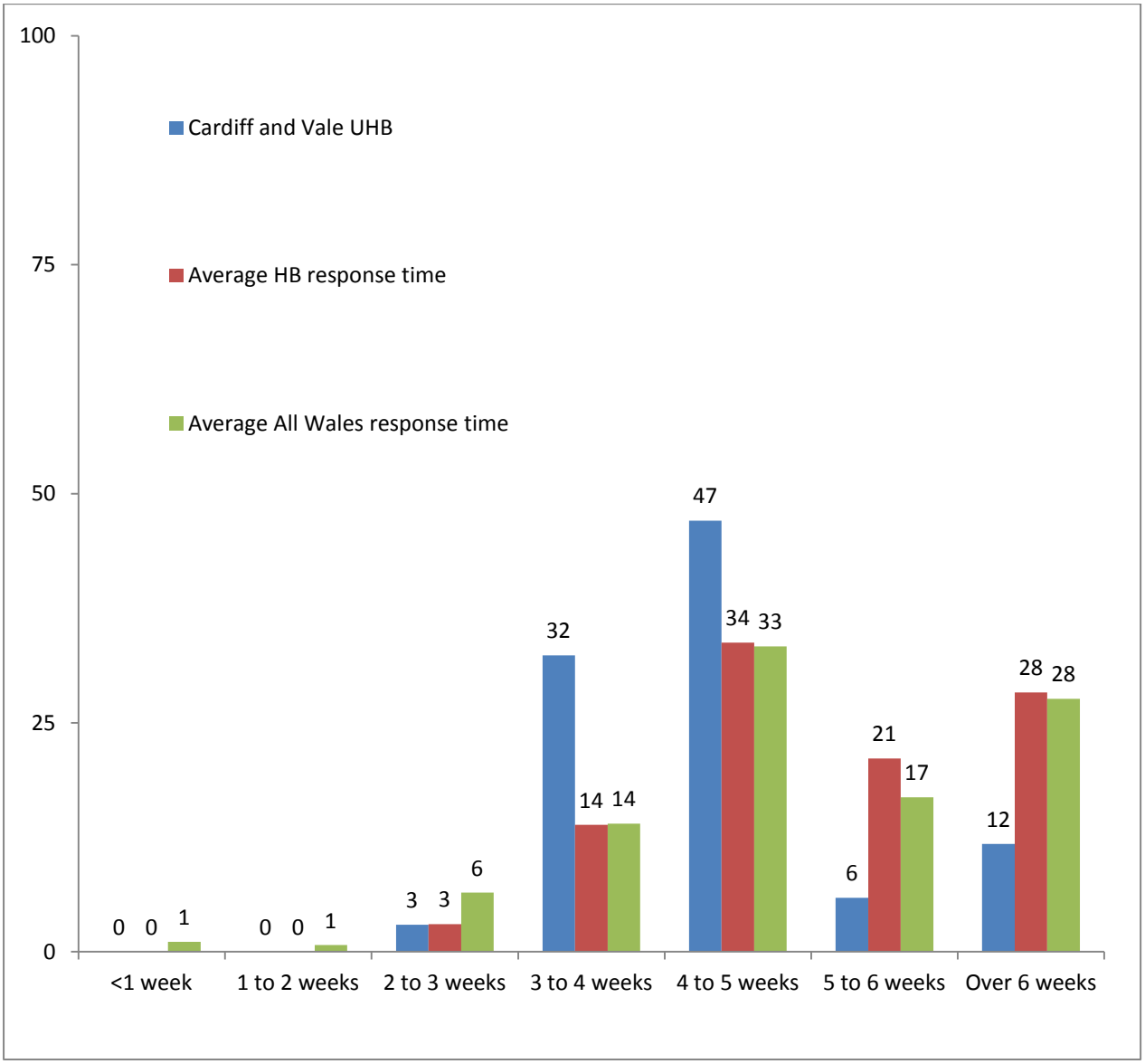
2012-2013



2011-2012



G: Comparison of Health Board times for responding to requests for information with average for health bodies and All Wales response times, 2012-2013 (%)



H: Report summaries

Health

Other reports – Upheld

March 2013 – Other – Cardiff and Vale University Health Board
Miss P complained that the Health Board refused to reimburse her for the cost of her breast cancer treatment, which she received in Germany. The treatment involved targeted radiotherapy to the tumour bed at the time of surgery instead of the usual radiotherapy given post surgery.

The Ombudsman found that there was no evidence that the decision had been improperly reached in the context of the law and guidance in place. The treatment which Miss P received was still being trialled in the UK at the time of her surgery and was not available on the NHS in Wales. Also, she had not made a formal detailed application and obtained the necessary approval in advance from the Health Board before proceeding with her treatment. The Ombudsman partly upheld her complaint in relation to the way in which the Health Board dealt with her request for a review of the decision but did not consider that this made any difference to the outcome. He reminded the Health Board of the need to address review requests properly and in accordance with its published procedure.
Case reference 201201236

March 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mr P made a complaint about the standard of care provided to his daughter, Ms M, when she experienced continuing pain following colorectal surgery.

The Ombudsman found that the investigations done and the clinical care provided was reasonable and appropriate. However, there were shortcomings in the record keeping, and in the communication both with Ms M and between the consultants involved in her care. The Ombudsman made the following recommendations:

• The Health Board should reminds all relevant medical staff of the necessity for effective communication, in line with GMC guidelines, both with patients about their condition and treatment plan, and between consultants where there is more than one specialty involved in the patient's care. This reflects the recommendation in a previous case (reference: 201203655) that the issues of communication, support to patients and consent should be reinforced at a consultants' forum and the results of this discussion should be disseminated to junior staff at a junior teaching session.
• The Health Board should ensure that there is appropriate clinical recording of consultations in line with GMC guidelines. The Health Board should review its clinical records' auditing to satisfy itself that it is effective in ensuring a good standard of clinical record keeping.
The Ombudsman also found that there were periods of delay in the Health Board's handling of the complaint, and recommended that the Health Board should review its handling of this complaint and ensure its current complaints handling procedures were compliant with Putting Things Right.
Case reference 201203412

March 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mrs F complained about the care and treatment provided by the LHB to her daughter Mrs W. In particular, Mrs F complained about the "unacceptable delay" (which had been accepted by the LHB) between staff requesting a doctor's attendance and someone arriving to review Mrs W on 7 January. She also complained about the care and treatment provided to Mrs W during the weekend of 6-8 January for meningitis.

The Ombudsman found that there was an unreasonable delay of around four and a half hours in Mrs W being attended to by a clinician on 7 January. Additional nursing advice provided enabled him to conclude that, as a result of the lack of available medical records, he could not be satisfied that Mrs W's pain was assessed or managed appropriately by nursing staff on 7 January.

The Ombudsman recommended that the LHB remind its nursing staff of their obligations to keep clear and accurate records in line with guidance from the Nursing and Midwifery Council. He recommended that the LHB apologise to Mrs W and make her a payment of £500 to reflect the period of pain and suffering that she endured on 7 January. The Ombudsman also recommended that if the LHB did not already have a policy in place for the escalation of contact to more senior staff in a medical emergency, that it put one in place. If the LHB already had such a policy in place, it should review the application of the policy in this case and provide reminders to staff of its content.

The LHB accepted the Ombudsman's recommendations.
Case reference 201201206

March 2013 – Other – Cardiff and Vale University Health Board
Ms A complained about the standard of care the LHB gave her mother ("Mrs B"). She said that Mrs B received extremely poor care and treatment during her stay in the Cardiac Intensive Care Unit of University Hospital Wales following complex cardiac surgery on 16 August 2011. Ms A believed that the staff failed in their duty of care and that the poor care and treatment resulted in her mother's death on 9 November 2011. Ms A also said that she was not satisfied with the way the LHB dealt with her complaint.

The Ombudsman's investigation considered Mrs B's medical records and information and comments provided by Ms A. Advice was given by three of the Ombudsman's professional advisers. The investigation did not find any evidence of a failing in the care given to Mrs B. Therefore, taking account of the clinical advice provided, the Ombudsman did not uphold that part of Ms A's complaint. The Ombudsman did find failings in the LHB's complaint handling and therefore upheld that part of the complaint.

The LHB accepted the findings and agreed to the following recommendations:

• apologise to Ms A for the failure to follow statutory guidance;

• share the report with all staff involved in complaint handling to ensure that they are aware of the need to recognise concerns that should be considered using statutory guidance;
• share the report with senior clinicians to ensure that, where there is a need to identify staff to complete an expert review, delays are minimised; and,
• put a simple process in place to ensure that, if such delays are experienced, the LHB has alternative options in place to ensure delays are minimised.

Case reference 201200885

February 2013 – Other – Cardiff and Vale University Health Board

Mrs R complained that the Health Board Hospital had not adequately supervised and cared for her 92 year old mother (M) who suffered from dementia. She had been assured that M was subject to 24 hour one-to-one monitoring (known as "specialling"). However, M had been able to make her way home early one morning, unnoticed – Mrs R maintains she had walked but the Health Board say M took a taxi that had been waiting outside. Mrs R was also unhappy with the results of the Health Board's own investigation and handling of her complaint.

The investigation could not reach a definitive conclusion as to how M had made her way home – both explanations were plausible. Nevertheless, M should not have been given the opportunity of doing so. The Health Board's own policy about taking breaks when specialling a patient (seeking cover before doing so) had not been followed in M's case, enabling her to leave. The Ombudsman was critical of this in light of clear documented evidence that M was likely to wander given the opportunity, and a documented attempt to leave the day before. This had not been commented on during the Health Board's investigation and Mrs R was not told about the earlier attempt. Furthermore, CCTV evidence which could have assisted was routinely retained for 28 days; whilst this was available during the Health Board's own investigation, it was not viewed and had been erased by the time the Ombudsman received Mrs R's complaint. Mrs R's complaints were upheld.

The Ombudsman made the following recommendations to the Health Board, all of which were agreed:

• offer an apology and redress of £300 for time and trouble to Mrs R;
• conduct a review of its specialling policy on breaks, further reinforcing it to staff as well as the importance of completing documentation; and
• view and retain CCTV where a complaint had been lodged, amending its investigation procedure to reflect this.

Case reference 201201382

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

Mrs S complained about the care and treatment given to her late mother, Mrs R, whilst she was an inpatient at the University of Wales Hospital between 25 and 30 January 2012. At the relevant time Mrs R was suffering from dementia and was resident in an EMI Nursing Home. In particular Mrs S complained about the Board's failure to obtain express consent to perform an endoscopic procedure under general anaesthetic upon Mrs R from her as next of kin. Mrs S also raised concerns about difficulties experiences obtaining information about her mother's well being on one

occasion during her admission and the way in which the initial complaints were dealt with by the Board.

With the assistance of clinical advice the Ombudsman concluded that whilst it was appropriate and reasonable for the Consultant to proceed with the procedure in Mrs R's best interests, the clinicians involved should have made some attempt to communicate with Mrs S or her sister in accordance with the consent guidance and good practice. The investigation also concluded that there was evidence of poor communication with Mrs S and her family. The Ombudsman was also satisfied that the Board's initial handling of the concerns fell below an acceptable standard. The Ombudsman did note however that Board responded very promptly once Mrs S's concerns had been logged as a formal complaint and did so within the prescribed period for response. The Health Board agreed to implement a number of recommendations arising from the issues identified and agreed to pay £500 to Mrs S and her sister in recognition of the distress and anxiety caused.
Case reference 201202557

January 2013 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mr X complained that clinicians at the University Hospital of Wales failed to correctly or adequately treat a fracture that he sustained to a bone in the palm of his hand. Mr X complained that the fracture was not set correctly resulting in a deformity, restricted movement and continued pain. Mr X also complained about the adequacy of the Health Board's handling of his complaint about this matter.

The Ombudsman did not uphold Mr X's complaint that there had been failings in the treatment of his injury. However, the Ombudsman did uphold Mr X's complaint about the Health Board's handling of his complaint and made the following recommendations, which were accepted by the Health Board:

• provide Mr X with a written apology for failures in the handling of his complaint; and,
• undertake a series of measures for ensuring and demonstrating awareness and compliance both with NHS complaint handling regulations and with the supporting Guidance informing their application.
Case reference 201103026

November 2012 – Clinical treatment outside hospital – Cardiff and Vale University Health Board
Mr Y complained that there had been shortcomings in the care and treatment which he had received through the Health Board's drug and alcohol services. He raised concerns about the service he has been offered from April 2007 onwards including his discharge from involvement which had immediate effect on 21 February 2011.

The Ombudsman found that up to the point of Mr Y's discharge from services that the care and treatment offered to Mr Y was in many respects reasonable. He noted that the Health Board had tried hard to support Mr Y in a difficult context. Nevertheless, due to the shortcoming in providing an agreed appointment and more significantly due to poor risk assessment and risk management processes being in place he partially upheld the complaint about the service offered to Mr Y.

In relation to Mr Y's immediate discharge from service the Ombudsman was concerned about the process that took place. The evidence suggested that although the Health Board had tried to support Mr Y over the period it had failed to address any concerns about Mr Y's behaviour in a formal manner in line with its policy. The Ombudsman noted that the Health Board's policies at the time had in place clear guidelines for dealing with such situations.
In Mr Y's case there was no evidence of a verbal or written warning having been provided as required. Additionally, the Ombudsman pointed out that communication with Mr Y should have been clearer about what other services were available to him at that time. To that extent he upheld Mr Y's complaint.

Recommendations were made for the Health Board to apologise to Mr Y for the shortcomings, offer him a review of his needs and provide £250 time and trouble redress payment. He also recommended that the Health Board reviewed how its substance misuse services assess and manage patient risk and that it ensured that the guidance on the management of abusive behaviour was followed. A further recommendation was made in relation to the need for a review of the clinical pathway to include reviewing the availability of psychological and talking therapies.
Case reference 201103068

November 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Ms M complained about the care and treatment she received at the University Hospital of Wales. She initially presented with a sudden onset of pain and could not bear weight. She was discharged with analgesia and advised to see her GP if there was no improvement. She subsequently attended on two further occasions as she continued to experience pain. She was consequently referred by her GP to the Orthopaedic department and following further investigation it was revealed that she had a fracture.

Having obtained clinical advice, the Ombudsman found that during her first attendance, the standard of care received was reasonable but the discharge arrangements were not. Further, on the second visit, the adviser considered that the record keeping was poor and that there was therefore insufficient information to establish whether or not further investigation was warranted. However, by her third attendance, she was displaying "red flag symptoms" and as such further investigation was warranted, not least a repeat x-ray and if that was normal, an MRI scan. The Ombudsman found that there were failings by the Health Board during each of her three attendances at A & E and that further investigation should have been carried out sooner and certainly following her third visit at the A & E department.

The Ombudsman made a number of recommendations to the Health Board and is pleased to note that it has accepted them in full.
Case reference 201200877

October 2012 – Clinical treatment outside hospital – Cardiff and Vale University Health Board
Ms C complained that the care and treatment provided to her daughter, Miss L, by a Mental Health Community Team in the Cardiff area (the Team), during the period September 2009 to August 2010 was inadequate, as the Team failed to obtain her

daughter's previous care notes and to consider the information provided by Ms C and Miss L on Miss L's mental health history. Ms C said that the Team also failed to properly assess her daughter's condition and to provide her with appropriate support and advice, in particular, with regard to her decision to live with her father and to attend college. She also had concerns about the transfer of her care and the steps taken by the Health Board to obtain her daughter's consent to the complaint.

The Ombudsman partly upheld the complaint. Having sought clinical advice, the investigation found that the Team had provided an appropriate level of care to Miss L and that the failure to obtain her care notes had not impacted on the standard of her care. The investigation found that the Team had facilitated and assisted Miss L in a decision which she, as an adult with full mental capacity, was entitled to make and that the transfer of her care was well co-ordinated.

The Ombudsman recommended that the Health Board should provide a full apology to Ms C and Miss L for the failure to provide Miss L's care notes to the Team and confirm the steps that it had taken to prevent similar failings from occurring in the future.

Case reference 201102119

September 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mrs A's daughter Miss P was admitted to the University of Wales Hospital ("the Hospital") on 14 August 2011 with abdominal pain, vomiting and diarrhoea. Following bowel surgery on 25 August, she developed debilitating post-operative complications and required many re-admissions to the Hospital. Mrs A complained to the Health Board about many aspects of her daughter's care and treatment but remained dissatisfied by the response.

The Ombudsman's investigation concluded that the investigations that were carried out in response to Mrs A's daughter's symptoms were very thorough and that the daily record keeping demonstrated this. More broadly, the Ombudsman was concerned about the lack of communication, including an informed consenting process by the clinicians involved in Miss P's care, which adversely affected the quality and nature of the care Miss P received. The Ombudsman was of the view that had a specialist nurse or an appointed key worker been more closely involved in Miss P's care at an earlier stage it might have alleviated some of the problems that she had faced since her first admission to the Hospital (on 14 August 2011). Mrs A's complaint was upheld.

In terms of complaint handling the Ombudsman concluded that the Health Board's response to Mrs A's specific concern was not sufficiently accurate, thorough or transparent and therefore upheld this aspect of Mrs A's complaint.

The Ombudsman's recommendations included:

•an apology through its Chief Executive to Mrs A in writing for the failings identified and make a redress payment of £250

•taking steps to ensure that its complaints procedure was compatible with the aims and objectives of the Welsh Government's Model Concerns and Complaints Policy and Guidance

•developing a care pathway for the management of patients with Inflammatory Bowel Disease which was compatible with the GuT journal and the guidelines stated by the Association of Gastroenterology

•to reinforce at a Consultant's forum the need to comply with the GMC and the RCS's guidance on consent and the importance of communication with patients and the person providing support to them and the outcome disseminated at a junior teaching session.

Case reference 201103655

September 2012 – Appointments/admissions/discharge and transfer procedures – Cardiff and Vale University Health Board

Mrs N complained about delay in the care and treatment of her spinal condition; she said that there were delays in the provision of spinal injections and in follow up appointments being provided. Mrs N also complained that a referral for her to see a second consultant could not be simply achieved.

The Ombudsman found that there were unreasonable delays in the UHB's care and treatment of Mrs N's spinal condition. The Ombudsman said that the earlier provision of appointments and treatment by the UHB may have provided Mrs N with some certainty as to her clinical options. The referral to the second consultant should have been made directly from the first consultant to the second, instead of also involving Mrs N's GP.

The Ombudsman upheld the complaint. He recommended that the UHB apologised for the delay in Mrs N's care and treatment and for the confusion around the referral to the second consultant. The Ombudsman asked the UHB to reflect upon his adviser's comments about follow up appointments and reconsider how it may best improve its procedures and/or current practice as a result. The UHB agreed to the Ombudsman's recommendations.

Case reference 201103903

September 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mr E complained about the care and treatment his wife (Mrs E) received during and after the birth of their son. He complained that a forceps delivery was attempted without appropriate permission or pain relief.

Mr E also complained that the monitoring of his wife's urine output following delivery was not carried out properly and, most critically, that a catheter was not placed. He said that, as a result, his wife did not pass urine for a significant period following delivery and that this ultimately contributed to the seriousness of the urinary tract infection (UTI) she subsequently contracted. He said that his wife's hospitalisation due to the UTI was prolonged.

The Ombudsman found that the care provided prior to and during the birth was appropriate. However, the Ombudsman was critical of the failure to place a catheter following the birth, which he concluded would have increased the risk of developing a UTI and its severity. The Ombudsman recommended that the Health Board apologise for this failing and remind its staff of the importance of post-delivery catheterisation.

Case reference 201200852

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

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

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

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

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

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

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

It was recommended that both Health Boards apologise to Mrs X for the delay in the clinical pathway leading up to Mrs Y's surgery and provide a combined redress payment of £1,500 to Mrs X and family for the time and trouble in making the

complaint and in recognition of the added distress caused by the delay. Both Health Boards were also recommended to review their procedures. A separate recommendation was made to Aneurin Bevan Health Board to ensure that ward staff undertook training in discharge planning.

Case reference 201101059 & 201101060

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

Mrs B complained about Cardiff and Vale University Health Board ("the UHB"). The complaints related to the care of her late father, Mr K at a hospital managed by the UHB. Mr K had been admitted to hospital with chronic constipation. He had many complex and serious conditions, particularly affecting his liver and kidneys. Eventually Mr K was discharged on Mrs B's insistence so that he could die at home. He did sadly die shortly afterwards. Mrs B raised issues concerning medical care, the hospital's approach to discharge planning, communications with family members and complaint handling.

The Ombudsman did not uphold Mrs B's complaint about medical care despite some misgivings. He upheld aspects of her complaint about the discharge process, particularly concerning the failure to procure a medical item which seemed to delay progress towards discharging Mr K. The Ombudsman strongly upheld Mrs B's complaint about communications, which he said fell below an acceptable standard and contributed to Mrs B's perception about medical care. The Ombudsman also criticised the UHB's complaint handling, which he concluded was superficial, slow and in one regard, insensitive. The Ombudsman made a number of recommendations. These included a payment of £500 to Mrs B as an acknowledgement of the failures identified, various reminders to medical staff and a process review regarding procurement.

Case reference 201102172

June 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mrs P's complaint concerned a number of administrative errors surrounding appointments and arrangements in respect of the cardiac care and treatment she received at the University of Wales Hospital ("the Hospital"). In particular she expressed concerns about the Consultant Cardiac Electrophysiologist's ("the Consultant") secretary providing her with medical advice over the telephone, and the Consultant's failure to fully explain that Mrs P required general anaesthesia (GA) for the procedure to treat her paroxysmal atrial fibrillation (intermittent irregular heart beat).

The Ombudsman's investigation concluded that the Consultant's reason for deciding to perform the procedure under GA was reasonable. However, he was critical that this was not explained to Mrs P at the outset and upheld this aspect of Mrs P's complaint. The Ombudsman noted that at the time of Mrs P's treatment the service was still in its infancy and this led to the administrative errors that Mrs P encountered. The Ombudsman said that the Health Board and the staff had a responsibility to ensure that an adequate infrastructure was in place to support new service development and upheld this aspect of Mrs P's complaint. As the Health Board had

already apologised to Mrs P about the Consultant's Secretary providing her with medical advice this matter was not considered further.

Amongst the recommendations the Ombudsman made was that the Health Board should apologise for the shortcomings identified by the investigation and make a redress payment of £250 in recognition of the time and effort Mrs P had had to expend in pursuing her complaint. The Health Board was also reminded of its obligation to ensure that any new service development is fully funded and staffed with appropriate pathways in place before treating patients. Finally, in addition the Health Board's Chief Executive was asked to provide this office with his written proposals for preventing a similar re-occurrence of the event.

Case reference 201102030

June 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Miss D complained that after her examination by a Consultant surgeon ("the surgeon") at the Hospital to where she had been referred, she was not told enough about her condition, or the surgical procedure which was performed. A scan had revealed an abdominal mass; an ovarian malignancy was suspected. After the surgeon's examination Miss D was informed that a laparotomy was recommended, and she was booked in for surgery six days later. Miss D complained that she had not been advised as to any other options available to her, or had the diagnosis fully explained to her, and that the surgeon had denied her request to see the scan. Therefore, Miss D complained that her consent to surgery had been uninformed, and that she was devastated by the loss of her organs. She also complained about the handling of her complaint, having had to chase for a response a number of times. Consequently, she had been extremely distressed by everything that had happened.

During the investigation advice was sought from the Ombudsman's clinical adviser. He was in no doubt that, clinically, the correct decision had been taken. There were no other treatment options in Miss D's circumstances. This aspect of the complaint was not upheld. However, the surgeon's record keeping was found to be inadequate in the recording of doctor-patient discussions, and so not in accordance with good practice on consent matters. It was also evident that the surgery was performed before the scan results were discussed at a Multi-Disciplinary Team meeting, albeit the outcome would not have differed. The Ombudsman upheld the complaint about the inadequacy of communication with Miss D and informed consent matters relating to the surgery. He also upheld Miss D's complaint about the UHB's handling of her complaint, which the UHB in responding to the Ombudsman agreed was unacceptable. The Ombudsman recommended that the UHB apologise to Miss D, offer her redress for the complaint handling issues of £300, and also that a Clinical Lead should reinforce the GMC's guidance on recording and consent issues to all consultants (and the surgeon in particular). The UHB agreed to implement all the recommendations.

Case reference 201102120

May 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board

The complaint was made by the parents of baby X and centred on the care and treatment that she received at the University Hospital Wales. Baby X was admitted to

hospital on 5 December 2008 and sadly passed away later that day. Mr and Mrs X were of the view that baby X's death might have been avoided.

The Ombudsman investigated the specific concerns that Mr and Mrs X raised. Firstly, that baby X had been placed on her back in her cot rather than on her stomach as had been specifically requested by Mrs X. The Ombudsman found that it was appropriate for the Health Board to follow the National Guidelines on the positioning of babies. Taking account of clinical advice he found that it was appropriate for baby X to be nursed on her back and that there was no evidence that this factor contributed to baby X's death. Nevertheless, shortcomings in communication (including there being no explanation available for families and no recording of baby X's needs and the wishes of her parents) led him to partially uphold this element of the complaint.

Secondly, Mr and Mrs X said that there was a failure by nursing staff to properly monitor baby X and they questioned the level of observation by staff. The Ombudsman found that the contemporaneous recording of baby X's observations was absent leading up to the critical time. It was therefore impossible for him to identify how much monitoring actually took place, and the impact that any greater monitoring could possibly have had. He could not reach a judgement on this. He noted that that the retrospective recording indicated that baby X's deterioration was sudden and observed and the clinical advice he received indicated that the treatment she received following her cardiac arrest was appropriate. He was however clear in his view that the practice in relation to patient recording fell well below the expected standard and to the extent that proper monitoring also includes proper record keeping he upheld this element of the complaint.

Finally the Ombudsman considered Mr and Mrs X's complaint that the explanation of baby X's death which they had received from medical staff was unsatisfactory and in this context he also considered the family's concern that baby X had choked on her own vomit. The Ombudsman found that the Health Board had attempted to help Mr and Mrs X understand what had happened to baby X but the accounts provided should have been clearer. He said that the Health Board should have endeavoured to explain the inconsistencies in the clinical records and discussed further the limitations in providing a definitive answer. He noted that the lack of recording of baby X's observations did not assist in this context. To that extent he upheld the complaint. Taking account of clinical advice the Ombudsman did not find evidence to indicate that baby X had choked but rather that baby X's sad death was instead a consequence of her very complex and serious congenital heart disease.

The Ombudsman recommended that the Health Board apologised to Mr and Mrs X for the shortcomings identified. He recommended that it put in place a clear policy/procedure regarding the arrangements for the sleeping position for babies/children, that it ensured that there were up to date care plans in place for all babies/ children and that it reviewed the local procedures and training needs of staff in relation to documentation and record keeping. In addition he recommended a redress payment of £1,500 to Mr and Mrs X for the added distress they had suffered.

Case reference 201100723

April 2012 – Clinical treatment outside hospital – Cardiff and Vale University Health Board & Aneurin Bevan Health Board

Mr D's complaint concerned the care provided for his late wife, Mrs D. Mrs D had had a kidney transplant. She received post-transplant care from Cardiff and Vale NHS Trust's ('the First Trust') Nephrology Team (Nephrology is a branch of medicine that focuses on the study and management of kidney disease). Mr D complained that the Nephrology Team did not listen to the concerns that he and Mrs D expressed about her fluid retention and weight loss. He considered that Mrs D's abnormal liver function test ('LFT') results should have triggered further investigation and an earlier referral to the First Trust's Hepatology Team (Hepatology is also a branch of medicine that focuses on the study and management of kidney disease) . He also implied that the Nephrology Team should have pursued this referral. He contended that the Nephrology and Hepatology Teams did not communicate with each other. He complained that Gwent Healthcare NHS Trust ('the Second Trust') did not attempt to drain Mrs D's fluid or to treat the cause of its retention.

The Ombudsman fully upheld Mr D's complaint against the First Trust. He partly upheld his complaint against the Second Trust. He recommended that Cardiff and Vale University Health Board and Aneurin Bevan Health Board should apologise, in writing to Mr D, for the failings identified and the unnecessary suffering that he, Mrs D and their family experienced as a result. He also asked them to arrange training related to specific fluid management guidelines and to develop joint strategies for facilitating timely transfers and improving communication between their hospitals. He recommended that Cardiff and Vale University Health Board should ensure that its Nephrology Team reviews its systems for identifying and reporting abnormal LFT results. He asked it to examine ways in which it can provide fluid drainage, on its wards, swiftly. He recommended that it should improve the Hepatology Team's operational arrangements. He asked it to ensure that its Nephrology and Hepatology Teams develop and use a common referral pathway for communication purposes.

Finally, he recommended that it should consider running a joint learning event, which addresses liver disease in kidney transplant patients and the management of fluid drainage, for its Hepatology and Nephrology Teams. Cardiff and Vale University Health Board and Aneurin Bevan Health Board agreed to comply with all of these recommendations.

Case reference 201002277 & 201102005

April 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mr. P complained about the urological treatment and care given to his late father during a hospital admission immediately prior to his death. Mr. P senior had been admitted to hospital with chest pain but was also awaiting operative treatment for the removal of a bladder tumour. Mr P raised a number of issues with the Board ranging from the cleanliness and condition of the facilities to the communication and record keeping of the staff. Having pursued his concerns directly with the Board, Mr. P asked the Ombudsman to consider an on-going concern he had relating to the management of a specific symptom of his father's urological condition.

The Ombudsman's investigation focused on solely on this issue. Advice was obtained from his professional advisors in relation to the management and treatment

of Mr. P senior's condition. The investigation found that Mr. P senior was extremely unwell prior to his death and that the nature of the treatment and rehabilitation required for his cardiac condition was such that it was appropriate for his urological symptoms to be managed as they were. The Ombudsman did not therefore uphold the complaint.

Case reference 201101632

Other reports – Not Upheld

February 2013 – Clinical treatment in & outside hospital – Cardiff and Vale University Health Board & GP in Cardiff and Vale University Health Board area
On 21 August 2012, Ms E complained about Cardiff and Vale University UHB ("the UHB") and a GP Practice ("the Practice"). She said that, following an accident in July 2011, she visited the Accident and Emergency department ("A&E") of a Hospital where an X-ray was taken of her hip. She complained that:

• the original diagnosis, based on an X-ray and an MRI, was wrong;
• between 26 July and 3 November she was not examined by a GP;
• she was not referred to specialists;
• the GP refused to arrange an MRI Arthrogram;
• there was no consideration for the cause of her pain; and,
• the Practice had not answered the questions raised in her complaint.

The Ombudsman obtained the medical records and comments from the Practice and the UHB. The Ombudsman also obtained advice from two of the Ombudsman's professional advisers. The investigation concluded that the original A&E diagnosis was correct; Ms E did not have a hip fracture. There was also no evidence that, between 26 July and 3 November, a clinical examination was omitted inappropriately. The evidence also showed that the Practice acted reasonably and the treatment of Ms E's pain was within the range of clinically acceptable practice.

The Ombudsman considered that the decision not to refer Ms E for an Arthrogram was appropriate because such a referral should properly be made by a specialist. The Ombudsman concluded that the Practice's account of its actions was supported by the records. The Ombudsman did not uphold the complaint.
Case reference 201201923 & 201202597

December 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mrs D complained about the orthopaedic care and treatment she received from the Health Board, in particular whether the decision made by the first consultant orthopaedic surgeon ('the first consultant') on 5 July 2011 not to operate to repair tears in her rotator cuff/bicep was a reasonable decision based on the results of the MRI scan at the time. Mrs D was also concerned about whether there was an impact on her recovery as a result of the delay in her receiving physiotherapy (seemingly between December 2009 and September 2010).

The Ombudsman found that the decision reached by the first consultant not to operate was reasonable and appropriate given the uncertainty of the origin of Mrs D's pain. The Ombudsman noted that appropriate tests and investigations were ordered in respect of this and that opinions from the neurosurgeon and second consultant were requested. The Ombudsman did not uphold the complaint.

The Ombudsman noted that the referral from the first consultant for Mrs D to undergo physiotherapy seemed to have gone astray and that the Health Board had apologised for this. He was however satisfied that an assessment by a

physiotherapist would have not have resulted in a different clinical outcome for Mrs D. He did not uphold the complaint.
Case reference 201200815

November 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mr X expressed concern that he had not received adequate care and attention during a hospital admission in November 2010. Mr X's complained that following a knee replacement operation his haemoglobin level dropped and he subsequently suffered a heart attack. During the Ombudsman's investigation it was found that Mr X's concern was at least in part caused as a result of inaccurate information having been provided by a Consultant.

Mr X also complained about the negative experience he had on a rehabilitation ward following surgery. Unfortunately Mr X suffered from loose stools at this time and as a precaution was barrier nursed and he could not change bed as he had requested. He was of the view that he was prevented from moving without good reason. He also said that on one occasion he was told that his stool specimen was lost.

The Ombudsman obtained clinical advice and concluded that the overall care and treatment provided to Mr X was reasonable. He however identified a number of shortcomings which in his view could be most appropriately addressed directly by the Health Board.

The Health Board subsequently agreed to confirm to Mr X how the Consultant's error occurred, provide an apology and share with Mr X the learning it had taken from his complaint.

The Ombudsman also brought to the Health Board's attention the shortcomings in the recording about barrier nursing and the limitations of its earlier written complaint response to Mr X on this matter. He also identified that the concerns expressed by Mr X whilst he was an inpatient had not been fully recorded and responded to.

A voluntary settlement between Mr X and the Health Board was reached in this case. This included a written apology and a follow up review meeting.
Case reference 201202304

August 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mrs P complained about the standard of care she received from the Trauma and Orthopaedic Department at University Hospital of Wales, Cardiff, after she broke her wrist in April 2011.

The Ombudsman found that the treatment Mrs P had received conformed to normal practice and was of a reasonable standard. It was regrettable that Mrs P continued to suffer pain in her wrist, but the pain was due to the nature of her injury rather than any failings on the part of the staff treating her. He did not uphold the complaint.
Case reference 201103955

August 2012 – Clinical treatment outside hospital – Cardiff and Vale University Health Board

Mrs Y complained about delay in removing retained products of conception (afterbirth) from her womb following her son's birth. She said that she had ongoing bleeding and discomfort. She also said that her son had not been treated appropriately to reduce the risk of infection from meconium in her waters, at delivery.

The Ombudsman after taking independent clinical advice found that Mrs Y's initial conservative treatment with antibiotics was appropriate and in line with national guidance. Such treatment could often be successful and avoided potentially risky surgery. The explanations for the continued bleeding following surgery were all reasonable. Overall there was no evidence that Mrs Y's treatment was inappropriate.

The Ombudsman also had no criticism of her son's treatment. The baby had no respiratory problems at birth and there was no need for him to be suctioned, as claimed by Mrs Y. This approach was in accordance with national guidance.

His findings were based on paediatric advice that there was no link between the presence of meconium in Mrs Y's waters and later concerns about her son's health. He noted that Mrs Y's son had continued to thrive and was no longer receiving medical attention.

Case reference 201101814

August 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board

Mrs A's husband, Mr A, had end-stage renal failure and in December 2006 commenced participation a research study of the licensed drug, Cinacalcet. During an admission to hospital in June 2009, Mr A developed vascular complications in both feet and lower legs that led to their amputation and he was later diagnosed with the condition calciphylaxis, a rare and often fatal condition where calcium is deposited in the blood vessels and skin. Mr A withdrew from the research study and his progress was further complicated by bleeding related to a rectal ulcer that could not be controlled due to the anticoagulant therapy he also required.

Sadly, Mr A passed away on 21 September 2009 having agreed with his medical team that his dialysis should stop. Mrs A complained that the calciphylaxis and rectal bleed were related to Mr A's participation in the research study. She said that Mr A would not have agreed to participate if he had known about the potential side effects of the drug being evaluated.

The investigation found that Mr A gave appropriate consent to take a part in the research study. Calciphylaxis was a recognised complication of end-stage renal failure and Cinacalcet was an appropriate drug therapy for Mr A in order to reduce the likelihood that the calciphylaxis might occur. Mr A's participation in a research study of the drug was largely incidental to the treatment and management of his condition which was considered to have been reasonable and appropriate. The complaint was therefore not upheld.

Case reference 201100263

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

Ms A complained about the NHS dental treatment carried out on her by postgraduate students at the Dental Hospital. Ms A subsequently paid for private dental treatment to correct the failed treatment. Having complained to the Health Board Mrs A remained dissatisfied with its subsequent response.

The Ombudsman's investigation established that Ms A was not receiving NHS dental treatment but was on a scheme where, for educational purposes, students at the local University carried out dental treatment. The investigation found that a lack of clarity in the documentation and referral process used by the Health Board meant that this distinction would not have been clear to Ms A. The Ombudsman felt that Ms A's complaint could be resolved by means of a settlement and approached the Health Board on this basis. The Health Board confirmed its acceptance of the settlement proposals which broadly were that:

• within one month of the settlement letter being issued, the Health Board's Chief Executive would apologise to Ms A for the shortcomings identified during the course of the Ombudsman's investigation and would pay Ms A redress of £2,500. This figure to include the cost Ms A had incurred in putting right the dental treatment, together with an amount to cover the inconvenience caused to Ms A of having to complain further to the Ombudsman's office due to shortcomings in the Health Board's investigation process.
• within three months of the settlement letter being issued, the Health Board, would:

(a) revise the documentation provided to patients (including those patients considering obtaining treatment under the educational route provided by non NHS students) so that they were given explicit information on the route under which they were being accepted, under what regulations they would be treated and what level of supervision the students would receive. Information about the relevant complaints procedure would also be displayed for patients' information.
(b) put in place procedures to satisfy itself that patients gave fully informed consent both before accepting treatment and during the treatment process and were informed of the benefits, risks and alternatives of treatment irrespective of the route by which treatment was being provided.

Case reference 201101472

Quick fixes and Voluntary Settlements

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

Mr C complained about aspects of his late mother's care during her admission at University Hospital Wales during August and September 2011. In his complaint to this office, he indicated that he would like an independent expert to consider the effects of the delay in his mother receiving treatment. My office contacted the Health Board, which advised that it was prepared to seek expert clinical advice to try and resolve the complaint.

Case reference 201204628

February 2013 – Complaint-handling – Cardiff and Vale University Health Board

Mrs I raised a number of concerns about the way her clinical complaints had been dealt with by the Local Health Board and (former Cardiff & Vale NHS Trust). Mrs I complained to the former Trust about her treatment in 2003 and then raised similar issues with the Local Health Board in 2010. In particular, Mrs I was concerned that the former Trust failed to record details or lost a record of a local resolution meeting held in 2003 concerning her complaints. Mrs I expressed concern also about a further meeting held in 2010 to discuss her complaints. Finally, Mrs I complained about the length of time taken by the Local Health Board to process her request for copies of her full patient records.

The Ombudsman commenced an investigation in relation to the administrative aspects of Mrs I complaints described above. After the investigation began, the prospect of settlement of the concerns was considered by the Local Health Board and proposals made and shared with Mrs I.

The Health Board agreed to provide a further explanation in respect of the issues raised in the complaint to Mrs I (as far as possible given the passage of time and available documentation). It also agreed to reimburse the fee paid by Mrs I for copies of her patient records and make a payment in respect of her time and trouble in pursuing her concerns. However, the Health Board clearly stated that the payment would not in any way represent a redress payment in respect of Mrs I's previous concerns about her clinical care. The complaint was settled on this basis without the need to prepare findings.

Case reference 201103317

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

Miss A's complaint centred on the management of her fertility treatment at IVF Wales. In particular, she complained that, at her pre-treatment planning appointment (in January 2012), she was not given a scan, despite requesting one as she was concerned that a return of her endometriosis could affect future IVF treatment. She also highlighted problems with her IVF treatment being delayed in March and May 2012. The latter delay was caused because a subsequent scan had revealed that her endometriosis had returned. Consequently, although Miss A had commenced hormonal injections and other measures, treatment that was to take place at another fertility centre to which she had been referred to could not continue. Finally, Miss A expressed dissatisfaction with the way that IVF Wales had conveyed information to her about her scan and an associated blood test.

The Ombudsman's investigation confirmed that Miss A should have had a scan in January 2012 as this was part of the standard IVF pre treatment plan provided to patients. The Ombudsman concluded that it was likely, on the balance of probability, that the issues relating to Miss A's endometriosis could have been addressed then and that consequently Miss A's first cycle of IVF treatment could have occurred within current waiting list guidelines. The investigation also identified that there were inadequacies in terms of IVF Wales' record keeping, such as the telephone discussion (concerning the scan and blood test result), not being fully documented. The Ombudsman therefore upheld these aspects of Miss A's complaint.

The Health Board agreed to the following settlement proposals, to be carried out within one month of the settlement letter being issued:

• the Chief Executive would apologise in writing to Miss A for the failings identified. In addition, in recognition of the distress and inconvenience that the Health Board's failings had caused Miss A it would make a payment to her of £500;
• the Health Board would review Miss A's position on the waiting list for her second cycle of IVF treatment and take steps to ensure that Miss A's position reflected the position she would have been in if her first cycle of IVF treatment had been completed in May 2012;
• staff at IVF Wales would be reminded of the importance of good record keeping; and,
• the Health Board would review Miss A's complaint and consider whether additional lessons could be learnt from it.

Case reference 201201720

September 2012 – Other – Cardiff and Vale University Health Board

Mr M complained that since making a formal complaint to the Health Board in May 2012, he was yet to receive a final response. My office contacted the Health Board, which agreed to provide Mr M with its final response within 10 working days.

Case reference 201202077

September 2012 – Continuing care – Cardiff and Vale University Health Board

The complaint, brought by solicitors instructed by Mrs J, related to the retrospective NHS Funded Continuing Care (NHSFCC) review in respect of the late Mrs S made by her daughter, Mrs J. Following the recommendation of Powys Teaching Health Board (the body responsible for dealing with NHSFCC reviews on behalf of Cardiff and Vale University LHB), that Mrs S was eligible for NHSFCC for a certain period during 1997 to 1999, it was requested that missing invoices for part of that period would need to be submitted in order for a reimbursement to be made in full. Due to the passage of time, it was unlikely that Mrs J would be in a position to obtain these invoices. On this basis, the solicitors said that the request was unreasonable. The solicitors also said that there were a number of similar cases regarding review payments that had recently come to light.

Having contacted the Health Board, it agreed that a meeting with Powys Teaching Health Board would be arranged to review these cases in general. The Ombudsman awaits the outcome of this meeting. It also agreed to make a full payment to Mrs J's

for the entire eligibility period. The Ombudsman concluded that the action taken by the Health Board was reasonable in order to settle the complaint.
Case reference 201201602

July 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board
Mrs T complained about the care provided to her late husband, Mr T, whilst he was an inpatient at the University Hospital of Wales. Mrs T complained that the Health Board failed to prevent Mr T's stroke and provide correct treatment. Mrs T complained that there were a number of questions which the Health Board had failed to answer during local resolution.

During the Ombudsman's assessment of the complaint, it was noted that the Health Board had provided two written responses to the complaint and had held two meetings with Mrs T to discuss concerns about the care provided. However, it did not appear that Mrs T had previously referred all of her questions to the Health Board before making the complaint to the Ombudsman. Consequently, the Health Board had not been given the opportunity to fully respond to the complaint.

The Health Board agreed to review Mrs T's questions to clarify whether or not an explanation had previously been given, and if not, to provide Mrs T with a written response within 30 working days.
Case reference 201200922

June 2012 – Other – Cardiff and Vale University Health Board
Ms M contacted the Ombudsman's office via email on 1 June 2012 outlining her concerns regarding the reimbursement for hormone treatment she paid for. Ms M felt that the Health Board was avoiding the reimbursement by requesting receipts and asking what hormones were used.

On receiving the email, my office contacted the Health Board for further clarification. The Health Board said that it was requesting receipts and clarification about which hormones were linked to which receipts. The Health Board agreed that it would reimburse Ms M in full, if she could confirm by e-mail that all the receipts were in relation to hormones that she had to purchase privately.

Subsequently, the Health Board informed my office that they had retracted their request for clarification regarding the receipts and would refund Ms M.
Case reference 201200924

May 2012 – Clinical treatment in hospital – Cardiff and Vale University Health Board
The Ombudsman received a complaint from Mrs M related to the Orthopaedic care of her husband, Mr M. Mrs M received an acknowledgement of her complaint, but had been waiting a number of months for a final response from the Health Board.

On receiving this information, the Ombudsman contacted the Health Board and requested that they wrote to Mrs M apologising for the delay in responding to her complaint, and sent a final response out within two weeks. The Health Board agreed to this request. Mrs M's complaint was closed on that basis.

Case reference 201200831