Our ref: MG/jm
Ask for: James Merrifield

Your ref:
01656 644 200

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

Ms Karen Howells
Interim Chief Executive
Hywel Dda University Health Board
Merlin's Court
Winch Lane
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Pembrokeshire
SA61 1SB

Dear Ms Howells

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 Hywel Dda 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 have 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 has 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 an increase in the number of complaints received and investigated, compared to 2012/13, and both figures are above the health board average. There has been a clear increase in the numbers of complaints relating to 'clinical treatment in hospital'. I am pleased to note that the number of complaints resolved by way of quick fixes or voluntary settlements is above the health body average, although you should note that so too are the number of 'upheld' reports issued by my office. I have also had reason to issue one Public Interest Report against your Health Board. Finally, it is of concern that89% of your Health Board's responses took more than five weeks of the date they were requested.

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, Hywel Dda 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.

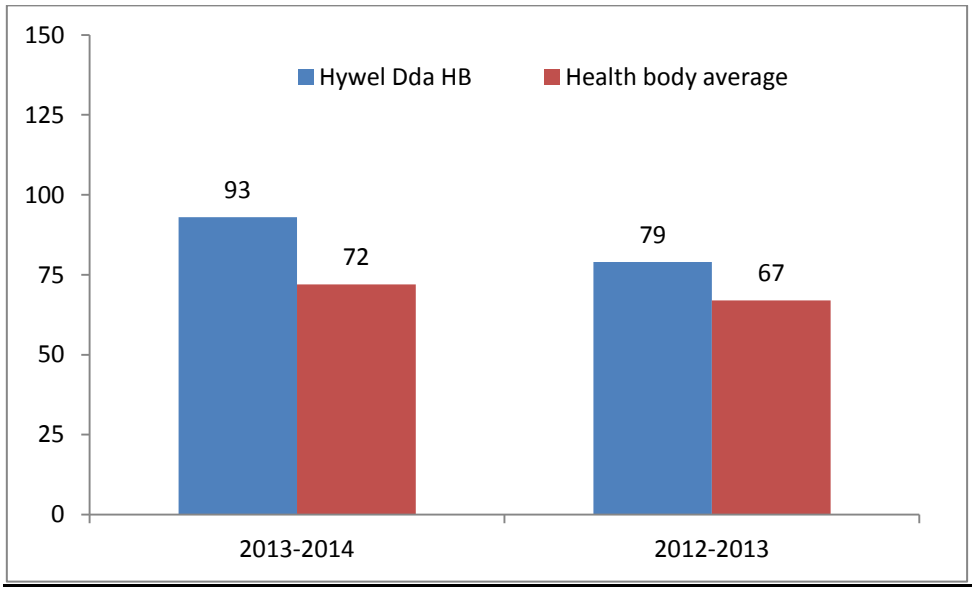
Section E compares the number of complaints against the Health Board which were taken into investigation by my office in 2013/14, with the average for health bodies (adjusted for population distribution) during the same period.

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

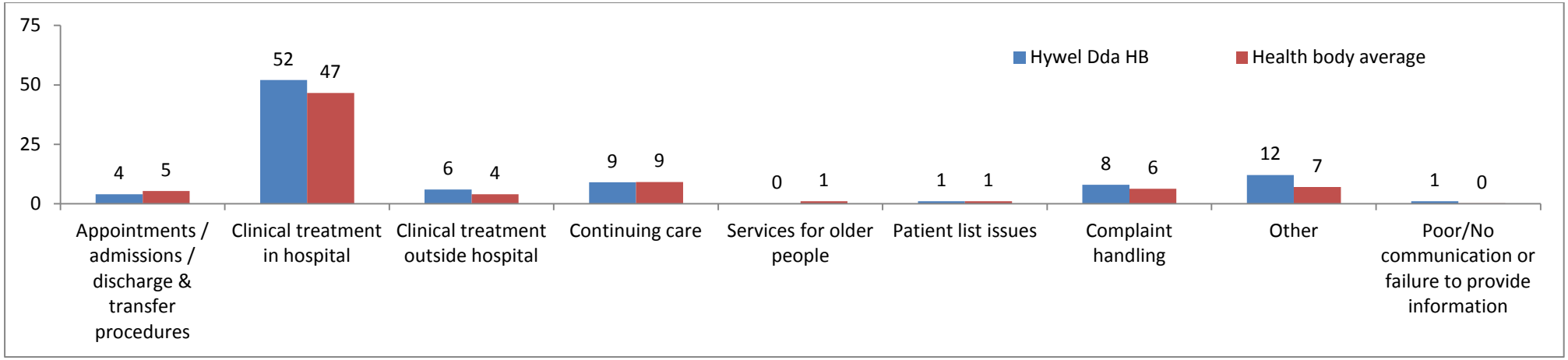


B: Complaints received by my office

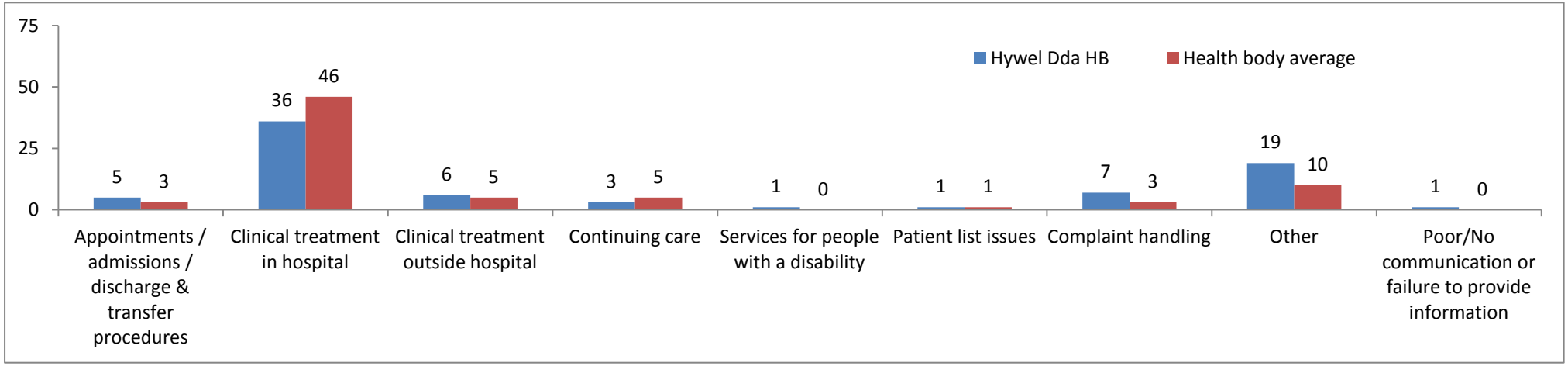
Subject	2013/14	2012/13
Appointments/ Admissions/ Discharge and transfer procedures	4	5
Clinical treatment in hospital	52	36
Clinical treatment outside hospital	6	6
Continuing care	9	3
Services for people with a disability	0	1
Patient list issues	1	1
Complaint-handling	8	7
Poor/no communication or failure to provide information	1	1
Other	12	19
TOTAL	**93**	**79**

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

2013/14



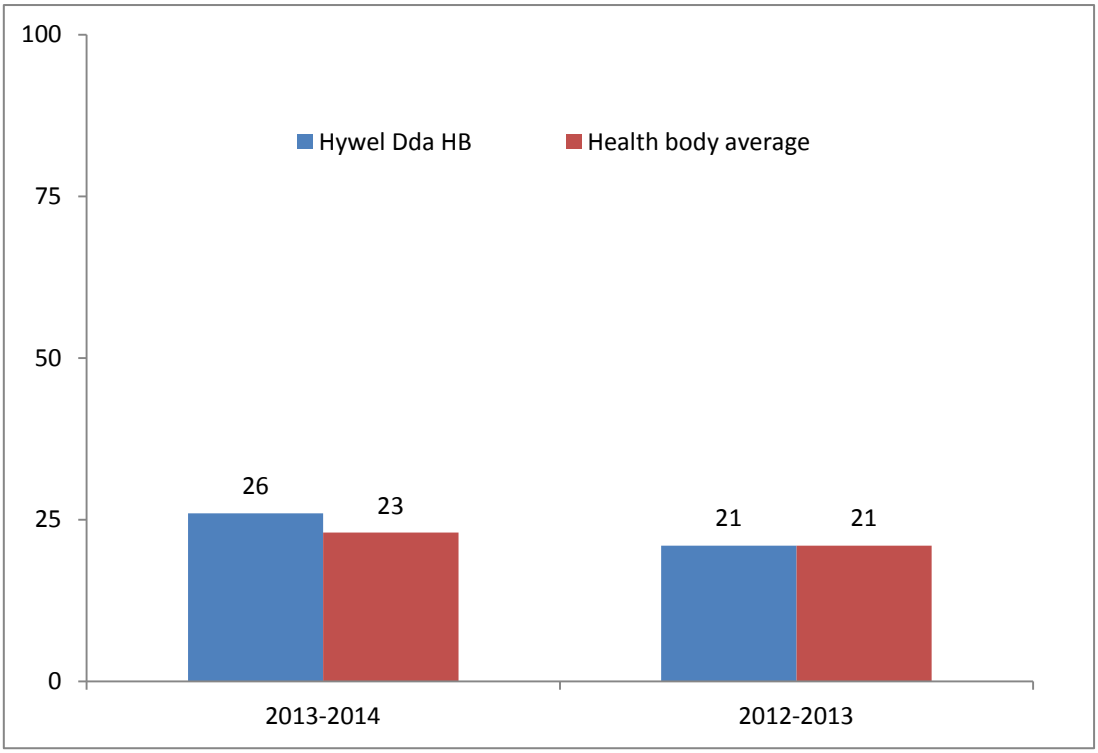
2012/13



D: Complaints taken into investigation by my office

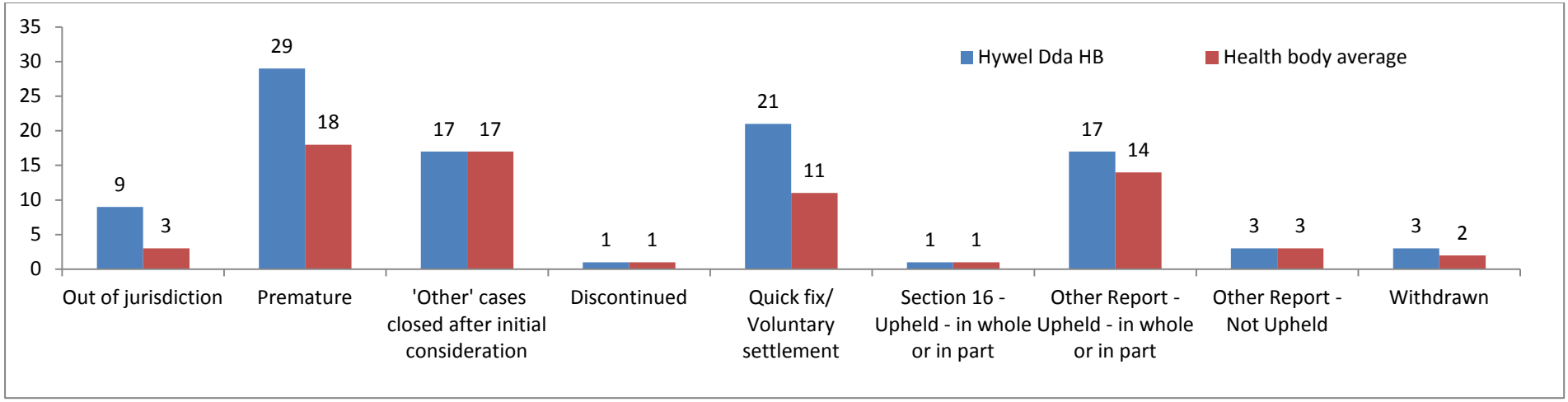
	2013/14	2012/13
Number of complaints taken into investigation	26	21

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

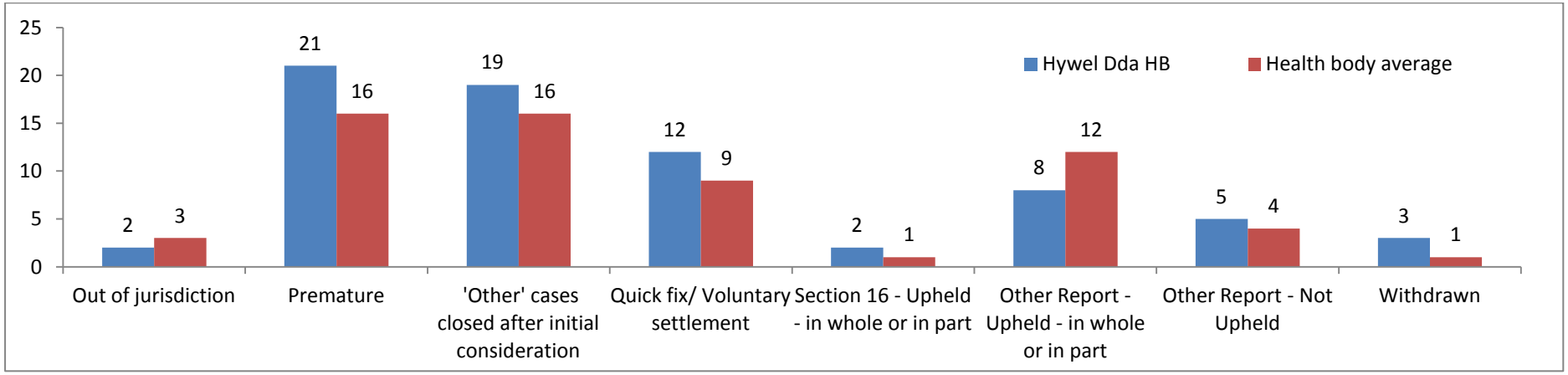


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

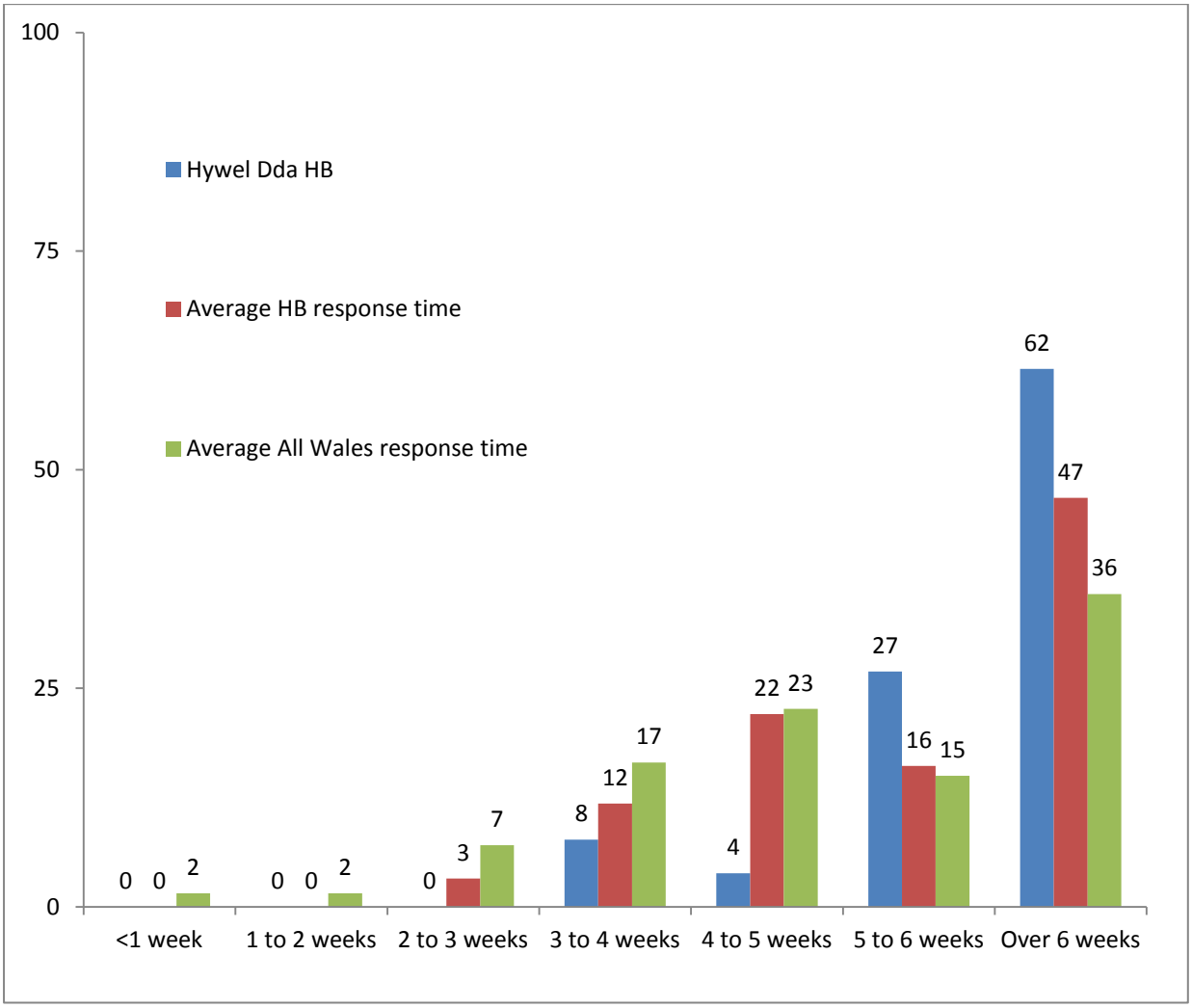
2013/14



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

August 2013 - Clinical treatment outside hospital - Hywel Dda Health Board
Mr R complained about the treatment of his late wife (Mrs R) by a GP she saw as part of the Out of Hours GP service (under the governance of the Health Board). After telephoning the service Mrs R was directed to see the GP at the designated Out of Hours centre (based at a major hospital). She suffered from lymphoedema to her left arm following cancer treatment and complained about feeling unwell with a developing blister rash on her left arm. The GP diagnosed shingles, giving her a prescription of a common antiviral drug. The following morning Mrs R collapsed at home and was admitted to A&E at the same hospital; she died later that day from complete organ failure as a result of sepsis. Mr R complained that the GP had failed to examine his wife properly, or to diagnose her correctly. He also complained about how the Health Board had handled his complaint.

The investigation found that there was no record of the GP performing a number of basic assessments including temperature, pulse, and blood pressure. The Ombudsman's clinical advisers also found that the GP had failed to have proper regard to Mrs R's pre existing lymphoedema. Whilst Mrs R's presentation might have suggested shingles, the GP ought to have also ruled out the blisters as a symptom of sepsis given it was well known that lymphoedema had a propensity to develop infection, which could lead to sepsis. An evident failure to consider this was unreasonable. Had it been considered, Mrs R could have been given antibiotics, or admitted to hospital that day – the GP ought to have adopted a risk-averse approach. This might have affected the outcome given that prompt intervention in suspected sepsis is critical to survival prospects.

The Ombudsman also found maladministration in the Health Board's complaint handling: ranging from delays, fundamental errors in letters and no acknowledgement or response to a relevant third party. In recognition of the seriousness of the issues, the following recommendations were made, all of which the Health Board accepted:

- written apologies to Mr R and to a relevant third party;
- redress of £4,000 to Mr R for the failures identified in the care of Mrs R and £500 for the complaint handling failures;
- the Lead Clinical Director should undertake a sample review of the GP's Out of Hours clinical consultation records (minimum 6 sessions) and that all GPs delivering Out of Hours services should be reminded of the importance of performing full assessments/examinations of patients and of recording those; and that
- the Health Board should ensure it had robust measures in place to secure timely and good quality responses to complaints.

Case reference 201202535

Upheld

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201203424 – Report issued January 2014

Mrs P complained about the treatment and care given to her late husband, at Glangwili General Hospital, when he presented with abdominal pain. Sadly he died a few days later from bilateral pulmonary emboli (Blood clots blocking the artery of both lungs; most commonly, the condition results from a deep vein thrombosis that breaks off and migrates to the lungs). She said that appropriate nursing care was not given and nursing staff did not take into account that her husband had Parkinson's disease. She also said that her husband was not given the appropriate medical treatment (medication and stockings) to prevent DVT (Deep vein thrombosis – a clot of blood which most often occurs in the deep veins of the leg and pelvis and may dislodge and travel to the lungs to form a pulmonary embolism) even though he was admitted to a surgical ward where such treatment was standard.

The Ombudsman found that there were some shortcomings in nursing care, which to its credit the Health Board had already acknowledged. The record of Mr P's fluid intake was confusing and unreliable and his medication had not been stored appropriately. However Mr P's condition had been recognised and taken into account to a certain extent and there was no absolute failure. Regarding medical care the Ombudsman said that there were some factors which may have made preventative measures unsuitable/unnecessary for Mr P. But there was no evidence that the risks of DVT had been properly assessed in his case and no recording of the reasons for not giving the usual preventative measures, which was poor practice. However the Ombudsman recognised the clinical difficulties in this case because Mr P was not presenting with the usual symptoms of DVT. Based on his medical advice, the Ombudsman could not say that the outcome would have been any different had the identified shortcomings not occurred.

The Health Board agreed to apologise to Mrs P and to provide evidence that the following recommendations had been complied with:

1. to audit the use of the risk assessment form for acute surgical admissions and the recording of the reasons where preventative measures were not prescribed;
2. to ensure systems were in place to monitor at ward level, compliance with local and national standards on safe medicine management and to make sure that patients with Parkinsons disease were given their usual medication, which could be outside the usual drugs round;
3. to audit the completion of fluid intake charts and their accuracy.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201204671 – Report issued January 2014

Mrs P complained that, following a hysterectomy carried out in Glangwili General Hospital ("the Hospital"), she was admitted to the Hospital via the A&E Department with a history of vaginal bleeding. Mrs P's complaint concerns the failure to carry out a scan when admitted to the Hospital resulted in additional pain and suffering to her and her family.

The Ombudsman's investigation concluded that there were shortcomings in the clinical management of her condition which resulted in a further readmission to the Hospital. Mrs P's complaint was **upheld**. The Ombudsman recommended that the Health Board should apologise to Mrs P for the shortcomings identified in her care.

Hywel Dda Health Board – Clinical treatment outside hospital
Case reference 201300416 – Report issued December 2013

Mr T complained to the Ombudsman about the manner in which his local GP and Hywel Dda Health Board had responded to raised levels of Prostate Specific Antigen (PSA) which were measured in 2010 and 2012. Mr T was diagnosed with prostate cancer in 2012 and considered that if he had been monitored appropriately the cancer would have been identified at an earlier stage. He also complained about the manner in which the Health Board had responded to his complaints and about its investigation into the actions of the GP. He also complained about the manner in which the GP undertook telephone consultations.

The investigation found that there had been shortcomings in the manner in which the Health Board and the GP had arranged for Mr T's PSA levels to be monitored between 2010 and 2012. It was considered that this would have been the responsibility of both the GP and the Health Board. It was also found that the explanations provided to Mr T following his complaint were inadequate. Whilst the actions of the GP in referring Mr T to secondary care in 2012 were found to be reasonable, shortcomings were identified in the GP's recording of her consultation with Mr T. It was considered that the manner in which the GP provided telephone consultations was reasonable as it was in keeping with accepted practice. The investigation also found that the GP and the Health Board had failed to deal with Mr T's concerns in a timely manner and in accordance with Welsh Government Regulations. Mr T's complaint was therefore upheld and the Health Board and the GP accepted recommendations that:

a. the GP should remind herself of her responsibility to be aware of NICE guidance; and to reflect upon her standard of record keeping and her clinical assessment and raise the case at her next appraisal
b. the GP familiarises herself with the requirements of complaints regulations so that in future her responses to complaints are managed in accordance with the guidance
c. the Health Board reminds relevant staff of the need to respond to complaints in a timely manner and to ensure that appropriate updates are provided to complainants
d. the Health Board and the GP issue a joint apology to Mr T for the failings identified in this report and pay him redress of £250.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201303520 – Report issued December 2013

Ms A complained about the care and treatment she received in Glangwilli Hospital ("the Hospital") where she was being treated for gynaecological problems. She complained that as a result of the poor care she received she lost the opportunity to have children. Ms A said that she subsequently arranged through her GP, a referral to a different hospital ("Hospital A") outside of the Health Board's area. Ms A said that at Hospital A it was discovered that she had significant problems including a

number of cysts and a surgical metal clip embedded in her bladder from a previous surgery she had at another hospital out-side Wales. Ms A also complained that she was given incorrect information about the cut-off age for IVF treatment. Finally, she complained about the delays in diagnosing her type 2 diabetes and the Health Board's complaint handling process.

The Ombudsman's investigation concluded that the clinical care and treatment that Ms A received was appropriate and reasonable and did **not uphold** her complaint.

In relation the cut-off age for IVF treatment the Ombudsman found no reference to this in Ms A's medical records and was therefore unable to reach a finding on this aspect of Ms A's complaint.

The Ombudsman considered that the eight months delay in responding to Ms A's complaint was unreasonable and upheld this aspect of Ms A's complaint.

Recommendations

a) That the Health Board should offer Ms A redress in the form of a written apology and a sum of £250 in recognition of the delay in responding to her complaint.

Hywel Dda Health Board – Clinical treatment outside hospital
Case reference 201201993 – Report issued November 2013

Mr Y complained about the lack of care and level of support for his young son who had Moebius syndrome[1] since birth and behavioural problems with learning delay and speech difficulties. He said that his son had been treated with various powerful drugs, which had not been reviewed promptly, following a diagnosis of ADHD[2] . He was concerned that his son's behavioural problems and threats of self harm had not been addressed.

The Ombudsman found, after taking clinical advice, that appropriate referrals had been made to various specialist services by the paediatricians. Concerns about Mr Y's son's threats of self harming had also been referred appropriately and the assessments and follow-up action carried out by the local CAMHS[3] team were reasonable. However, the Ombudsman concluded that there was no evidence to suggest that the original diagnosis of ADHD was based on widely accepted diagnostic criteria and that the diagnosis was therefore questionable. He also found that there was a failure by paediatricians to monitor any possible side effects as the result of the introduction of powerful ADHD drugs and following subsequent drug changes. The Ombudsman also found that there was unreasonable delay in responding to Mr Y's complaints.

The Health Board agreed with his recommendations to:

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[1] Congenital neurological disorder characterised by facial paralysis and an inability to move the eyes

[2] Attention Deficit Hyperactivity Disorder-possibly a genetic disorder associated with behavioural problems including inattentiveness and/or hyperactivity

[3] Child and Adult Mental Health Service

a) apologise for the shortcomings and make a payment of £250 for the "time and trouble" in making the complaint;
b) review the diagnosis of ADHD, with the family's agreement, using the recognised diagnostic criteria.
c) take action to ensure that the delay in monitoring did not happen again and that children in a similar position were given prompt follow-up appointments following the introduction of ADHD medication;
d) remind staff to continue to actively monitor side effects following changes in medication;
e) ensure that an ADHD pathway (giving time limits for review) was in place within four months of the date of issue of the Ombudsman's report.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201202895 – Report issued November 2013

Mr A complained about the general mental health care that he had received from Hywel Dda Health Board ("the Health Board"). He indicated that Psychiatric Nurses, Psychologists, group talking therapy and one-to-one sessions, could not meet his mental health needs. He suggested that he should be able to see a Consultant Psychiatrist without having to access the Community Mental Health Team ("CMHT") first. He also complained about the care that he had received after a suicide attempt. He said that two surgeons examined him even though he had refused medical assistance. He told us that the Health Board did not complete a psychiatric assessment or offer him the opportunity to talk to a doctor, with psychiatric experience, prior to discharging him from hospital. He said that it did not give his carer information, about his condition, during his admission. He told us that the CMHT staff members, who visited him after his discharge, were not qualified to determine whether he required secondary mental health services.

The Ombudsman did not uphold the general care aspect of Mr A's complaint. He partly upheld the incident-specific element of it because the Health Board did not formally assess Mr A's capacity, make sufficient efforts to address his medical condition prior to discharging him or involve the Psychiatric Team in his care. He recommended that the Health Board should:

a) write to Mr A to apologise for the incident-specific failings identified;
b) consider a Practice Toolkit for improving mental health care in Emergency Departments;
c) provide mental health training for staff members within its Emergency Departments;
d) review the CMHT's documentation and disseminate recording-related learning points;
e) ensure that his investigation report is discussed with staff members.

The Health Board agreed to comply with these recommendations.

Hywel Dda Health Board – Clinical treatment outside hospital
Case reference 201102695 – Report issued October 2013

Mr & Mrs B complained about the care and treatment provided for their daughter, Jane, by the Child and Adolescent Mental Health Team ("the CAMHS team") of Hywel Dda Local Health Board in connection with her eating disorder. In particular,

they complained about what they considered to be inadequate/inappropriate treatment and the delay in applying for funding for Jane to be treated at a more specialist centre out of the Health Board's area. They also complained about inadequate communication with the family, inadequate and inappropriate record-keeping, the failure to obtain their consent to a referral to the social services department and inadequate investigation of their complaint.

The Ombudsman largely upheld the complaint. He found that the CAMHS team had not recognised the seriousness of Jane's illness; they should have recognised that the necessary expertise was not available locally and applied for funding for the specialist centre much sooner than they did. The Ombudsman found failings in the way in which the CAMHS team communicated with Mr & Mrs B, and that the record-keeping was on occasions inadequate and indicative of a breakdown in the relationship between them and professionals. Mr & Mrs B should have been asked for their consent for the referral to social services, and the Health Board should have been more willing to accept earlier in the complaints process that there had been failings.

The Ombudsman recommended that:

- The Health Board apologise to Mr & Mrs B for the failings identified.
- The Health Board make a payment of £1500 to Mr & Mrs B in recognition of the failings which had been identified
- The CAMHS team consider developing procedures for active risk management on referrals where the information to enable professionals to evaluate risk is missing
- The Health Board should use its best endeavours to establish an agreement with WHSSC identifying what services are **not** available locally and which will therefore need to be the subject of an application for funding from WHSSC

- The CAMHS team should develop guidelines for regular physical monitoring, including the recording of weight, of children presenting with anorexia nervosa
- The CAMHS team should review how it works in partnership with patients/parents to ensure that shared decision-making becomes a central part of its practice, if it has not already done so
- The Health Board should remind practitioners of the importance of ensuring that their recordings are evidence-based, and of considering how they can be perceived by those about whom the records are made
- The Health Board should remind its staff of the need to obtain consent for a "child in need" referral, and of the importance of maintaining patient confidentiality.

The Health Board agreed to implement the recommendations.

Hywel Dda Health Board – Clinical treatment outside hospital
Case reference 201203391 – Report issued October 2013
Mrs R complained that medication she had been prescribed to treat her mental health condition caused her severe physical side effects and that the doctors treating

her did not take timely action once this became apparent. Mrs R was also concerned about the way the Health Board dealt with her complaint.

The Ombudsman found that while there was little doubt that the medication was responsible for Mrs R's physical symptoms (and this was recognised by the doctors treating her), there was a need to balance the risk of the side effects with Mrs R's ongoing need for treatment of her mental health problems. While highly sympathetic to the unenviable situation Mrs R had found herself in, and while recognising that there were some matters that with hindsight could have been handled differently, the Ombudsman concluded that, overall, Mrs R's care and treatment fell within acceptable clinical practice. He did not uphold this part of her complaint. The Ombudsman did uphold Mrs R's complaint about how her complaint to the Health Board was dealt with as there was significant delay in the Health Board's response.

The Ombudsman recommended that the Health Board should:

a) apologise for the failings identified and pay Mrs R £250 in recognition of the additional distress and time and trouble caused by the delay in responding to her complaint;
b) remind clinicians of the need to ensure discussions with patients about potential side effects are adequately recorded;
c) consider reviewing the adequacy of availability of access to inpatient admissions.

August 2013 – Other – Hywel Dda Health Board
Mr B complained about both Hywel Dda Local Health Board ("the Health Board") and his GP (who at the time was a partner in a practice in the area of the Health Board, but who has since retired). Mr B complained about the information which the GP put in letters of referral to the Health Board's Community Mental Health Team ("CMHT") and the failure by the GP to follow up the first referral. He also complained about the way in which the Health Board dealt with the referrals, and the way in which it handled his complaint.

The Ombudsman partly upheld the complaint against the Health Board. He found that there was no evidence that the Health Board had received the first referral, and that it had dealt appropriately with the subsequent referral. However, he was critical of the fact that the complaint had been investigated by the person against whom it was made.

The Ombudsman also partly upheld the complaint against the GP. He found that the content of the GP's referral to the CMHT, although sparse, was adequate and accurate. Although he did not criticise the GP for failing to follow-up the first referral, the Ombudsman was critical of the GP's failure to inform Mr B of the CMHT response to the second referral, and of the way in which the GP dealt with Mr B's disagreement with the content of the referral.

The Ombudsman recommended:

- the Health Board apologise to Mr B;
- the GP apologise to Mr B;

- the practice introduce a system for following-up referrals;
- that the practice review its systems for amending its records in the event that a patient disagrees with information contained therein

The Health Board, the GP and the practice agreed to implement the recommendations.

Case reference 201201511

July 2013 – Clinical treatment in hospital – Hywel Dda Health Board

Mrs A complained about the care that the former Hywel Dda NHS Trust ("the Trust") provided for her late son, Mr B. She said that it took too long to investigate his condition and to treat his cancer. She suggested that it did not manage his pressure care properly or address the delay in the delivery of his oxygen promptly. She contended that Mr B suffered unnecessarily and died sooner than might have been the case, because of the Trust's alleged failings. She said that its management of the social and psychological aspects of Mr B's care was also lacking.

The Ombudsman upheld Mrs A's complaint because he considered that the Trust's diagnosis and treatment of Mr B's cancer was unreasonably delayed, its pressure care lacking, and its response to Mr B's social and psychological needs deficient. He recommended that Hywel Dda Health Board ("the Health Board") should write to Mrs A to acknowledge, and apologise for the failings identified. He asked it to share his investigation report with staff members. He recommended that it should prepare a statement, outlining how it intends to manage the diagnosis and treatment of cancer, when its primary site is unknown, with reference to relevant guidance. He asked it to satisfy itself that it can provide results from a particular type of diagnostic testing, promptly. He recommended that it should instruct its Community Nurses to ensure that their pressure care practice complies with its guidance. He also asked it to tell them to ensure that their end of life care complies with the relevant practice model and that their record keeping reflects this. The Health Board agreed to comply with these recommendations.

Case reference 201201487

June 2013 – Appointments/admissions/discharge/transfer procedures – Hywel Dda Health Board

The complainant's mother-in-law, Mrs Y, was admitted to Glangwili hospital following a fall at home, with a suspected stroke or TIA[4]. She was discharged two days later, without advising the family, to the care of an elderly neighbour.

The Ombudsman found that Mrs Y's discharge was premature and rushed. A MAST[5] assessment, carried out by an occupational therapist, found that Mrs Y was confused, unsteady on her feet and was in need of formal support twice a day. But she was discharged without ensuring that adequate support was in place for her subsequent care. There was an absence of informing sharing between colleagues and continuing concerns were not communicated to the medical staff or to the family. Further investigations about Mrs Y's mental capacity/confusion had not been carried

[4] Transient Ischemic Attack – sometimes called a mini stroke

[5] Multi Disciplinary Assessment Support Team

out and there was a lack of clear record keeping by the occupational therapist. Overall the Ombudsman found a failure of the multi disciplinary team to arrange a safe discharge and to comply with the Health Board's policy on discharge planning. There were also shortcomings in complaint handling.

The Ombudsman made recommendations to remind staff of the need for good communication to achieve safe discharge, in compliance into the Health Board's policy. £250 was paid to the complainant for his time and trouble in making the complaint.

Case reference 201201594

May 2013 – Clinical treatment in hospital – Hywel Dda Health Board

Mrs A complained about the standard of care and treatment her late husband received from the out of hours doctor. She also complained about the nursing care he received towards the end of his life. Mrs A was dissatisfied with the Health Board's response to her complaint.

The Ombudsman's investigation identified inadequacies in record keeping by the out of hours doctor. Clinical failings were also identified. These included a failure to carry out a thorough consultation during the house call and not correctly establishing the correct dose of Mr A's morphine (Oramorph) which resulted in him being hospitalised as a result of opiate poisoning. The Ombudsman was also concerned that the out of hours doctor had failed to address these issues or recognise their impact on his clinical practice. Mrs A's complaint was **upheld**.

The Ombudsman concluded that there were shortcomings in the nursing care that Mrs A's husband received. The Ombudsman welcomed the Health Board's acknowledgement of shortcomings in the care provided to Mrs A's husband. Mrs A's complaint was **upheld**.

The Ombudsman highlighted concerns about the robustness of some aspects of the Health Board's complaint handling. In particular, insufficient regard had been given to the clinical failings of the out of hours doctor. The Ombudsman again **upheld** this aspect of Mrs A's complaint.

Amongst the recommendations the Ombudsman made was that a formal apology should be made to Mrs A for the failings identified by the Ombudsman's investigation. In addition, the Health Board should make a payment of £1000, as an acknowledgement of the distress caused to Mrs A by failures in care during her husband's last weeks of life, which have been compounded by the shortcomings in the Health Board's complaint handling.

The Ombudsman's report is be shared with the out of hours doctor and provide evidence that this case has been critically reviewed as part of the out of hours doctor's annual appraisal. The Health Board to make arrangements for the out of hours doctor to attend a prescribing training course on morphine.

Case reference 201200759

April 2013 – Continuing Care – Hywel Dda Health Board

In 2006, Mr E suffered a traumatic brain injury. Mr and Mrs M, his parents, provide 24 hour care to him. In 2009, the Ombudsman issued a public report about a Local Health Board's failure to provide statutory services to Mr E. [6] In April 2010, Hywel Dda Local Health Board ("the LHB") confirmed that Mr E qualified for NHS Continuing Healthcare Funding ("CHC funding"). In June 2012, Mr M again complained to the Ombudsman about services provided by the LHB. In summary, he said that:

- the LHB had failed to provide the quantity and type of physiotherapy required and the planned future physiotherapy was also not as Mr M expected;
- he had to arrange private physiotherapy and purchase equipment to make up the alleged shortfall in agreed provision;
- the therapy that had been provided had not been coordinated;
- there has been no Occupational Therapy ("OT") provided for 2 years.

The investigation considered evidence from Mr M and the LHB alongside guidance published by the Welsh Government, entitled: "Continuing NHS Health Care: the National Framework for Implementation in Wales" ("the Framework"). The Ombudsman obtained advice from an experienced clinical physiotherapist who specialises in neurological rehabilitation ("the Adviser"). The Adviser said that, apart from two periods, the quantity, frequency and type of physiotherapy mentioned met the recommended format. Therefore, the Ombudsman partly upheld this aspect of Mr M's complaint.

The Ombudsman's earlier report had criticised the LHB's record-keeping and communication with Mr E's family. This investigation also found similar failings. The investigation found evidence that the LHB failed to fully inform Mr E and his family about the CHC Funding assessment and review process; failed to formally notify Mr M of the April 2010 decision; failed to maintain the records specified by the Framework; failed to advise Mr M and his wife of their right to have their needs as carers assessed and failed to consider Mr M's concerns about the care being provided to Mr E using the relevant statutory guidance. [7] The investigation found evidence that the therapy provided had not been properly coordinated. Therefore, the Ombudsman upheld this part of the complaint.

The investigation did not find any evidence to suggest that the equipment purchased by Mr M was specified in the LHB reports. Therefore, the Ombudsman did not uphold this part of the complaint. The Adviser said that the LHB's OT recommendations were aimed at increasing the activities that Mr E could undertake

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2 Report reference 200800779, issued under S16 of the Public Services Ombudsman (Wales) Act 2005

3 Complaints in the NHS, a Guide to handling complaints in Wales, April 2003. The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and "Putting Things Right 2011.

4 Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care and Continuing NHS Health Care: the National Framework for Implementation in Wales.

outside of the home and to have more control of his environment. The investigation did not find any evidence to demonstrate that the OT provision was not clinically appropriate. It did identify that Mr M had declined the OT provision. Therefore, the Ombudsman did not uphold this part of the complaint.

The Ombudsman made a number of recommendations, including that the LHB should:

- develop, agree with Mr E, and implement, Personal Care Plans which fully comply with the Framework;
- make payments to Mr E and Mr M for the failure to comply with Welsh Government guidance[8] when managing Mr E's care; for the missed physiotherapy sessions and for the time and trouble in making this complaint;
- give unreserved written apologies to Mr E and Mr M for the identified failings;
- audit, and if needed, update all policies and procedures related to CHC Funding to ensure full compliance with the Framework.

Case reference 201301083

Not Upheld

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201302409 – Report issued March 2014
The investigation considered Mrs X's care and treatment following a silent miscarriage in April 2013 when she was 5-6 weeks pregnant. Mrs X complained about the administration of medication in the medical management of the miscarriage, in that her body had not absorbed the second dose of medication, and about a lack of action when she had heavy bleeding for an extended time following the miscarriage.

The complaints were not upheld. The guidance (Ectopic Pregnancy and Miscarriage, published in December 2012) issued by the National Institute for Health and Social Care and introduced shortly before these events, indicated that the second dose of medication was unnecessary. The Health Board agreed to check that it has since updated its internal procedures for medical management of miscarriage in line with the NICE guideline. Further, while Mrs X's experience of continued bleeding was frightening and distressing, there was no failure of care. Although she had been told to contact the ward if she had any problems, it was subsequently reasonable for the hospital to direct her to seek treatment through her GP and A&E. However, the Health Board agreed to share the Ombudsman's report with the senior nurse responsible for the ward to note Mrs X's experiences.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201204102 – Report issued January 2014
Mr X complained that the flexible cystoscopy procedure (an investigation performed by inserting a thin, flexible tube into the trethra and up into the bladder), which he underwent at Withybush General Hospital in 2011, was performed "poorly" leaving him in chronic pain and causing him considerable distress. Mr X questioned whether the procedure had been necessary because the urine test undertaken before the procedure did not show the presence of blood. He questioned the sterility of the equipment used for the procedure.

Mr X also complained about inaccurate information contained in the Health Board's written response to his complaint which was contrary to his account. The Health Board had said that he had been suffering from pain and frequency of urine before the procedure, which he said was untrue.

The investigation found that it was appropriate for the investigation, and therefore for the flexible cystoscopy procedure, to be undertaken. There was no evidence that the procedure had been poorly undertaken or that the equipment used had not been properly sterilised.

The Health Board accepted that the information contained in its written response to Mr X had been inaccurate, and it apologised appropriately for that.

The complaint was therefore not upheld.

Hywel Dda Health Board – Other
Case reference 201204733 - Report issued November 2013

Mr C complained to the Ombudsman that, in January 2012, he had a ruptured gall bladder which, he said, should have been dealt with by the NHS before it ruptured. He said that because of a long waiting list, and a conversation with his GP, he had sought private treatment. He said that he thought Hywel Dda Local Health Board (the LHB) should reimburse his private care costs, but the LHB had refused to do so.

The Ombudsman considered Mr C's medical records and other relevant information from the LHB and his GP. The Ombudsman also obtained advice from an experienced Consultant Surgeon. The investigation confirmed that in January 2012 the LHB failed to arrange an appointment with a surgeon following a successful ERCP (a procedure which helps identify any abnormalities in the gallbladder). The LHB later apologised for that error. On 30 January, Mr C saw his GP who offered to make a referral to the local hospital. At that point, Mr C knew that the waiting time for routine surgery was approximately 36 to 39 weeks. His condition was, medically, "routine" and, from that perspective, he would have been able to wait for surgery.

If Mr C had allowed the GP to refer him, the LHB would have been obliged to correct the earlier error it had made. However, he chose to seek private care. He said he did so because his GP told him to; his GP disputed this. The records supported the GP's recollection of the discussion that took place. The investigation concluded that the LHB was not required to reimburse the private care costs and the complaint was not upheld.

Quick fixes and Voluntary settlements

Hywel Dda Health Board – Complaints Handling (Health)
Case reference 201301405 – March 2014
Mr A complained about his difficulty accessing services at the NHS Dental Practice he usually attended. He was also dissatisfied with the Health Board's response to his concerns about the matter. The Ombudsman contacted the Health Board, which agreed to provide Mr Jones with a more robust response to the concerns that he had raised in accordance with the NHS complaints procedure.

Hywel Dda Health Board – Continuing care
Case reference 201205132 – March 2014
Ms X complained, on behalf of her client, Miss Y, about the Health Board's decision not to offer a payment for the NHS Funded Continuing Care (NHSFCC – a payment by the NHS of care fees for those found to have continuing or complex health care needs) retrospective claim for reimbursement of fees paid for the care of her relative, the late Mr Z, when he was resident at a care home for the period June 2000 to March 2001. The Health Board had been of the view that there was insufficient proof of the payment made to the care home which, it said, made calculating what should be reimbursed impossible, despite the resident being found to be eligible for NHSFCC for the period in question.

While this complaint was being investigated, the Welsh Government issued guidance ("Continuing NHS Health Care (CHC) in Wales: Interim Guidance on Reimbursement for Retrospective Claims processed by Powys Project") which was directly relevant to the disputed issue. The Health Board subsequently agreed to apply the guidance to this case and to reconsider the reimbursement offer for the period in question. As a result, the complaint was resolved and the matter was considered settled.

Hywel Dda Health Board – Continuing care
Case reference 201304143 – January 2014
A solicitor complained that, after concluding Mrs V's care needs did not meet the criteria for Continuing NHS Health Care funding, the Health Board incorrectly considered the four key indicators (nature, intensity, complexity and unpredictability).

The solicitor also complained that the Health Board:

- considered an incorrect definition of intensity and of complexity;
- should not have considered the nursing home's ability to manage Mrs V's needs;
- misinterpreted Mrs V's needs relating to her nutrition and altered states of consciousness; and,
- ailed to recognise that her cognitive impairment was an intense health need and that Mrs V had an intense health need in relation to her mobility and a number of complex health needs including those relative to her skin and mobility.

The Health Board accepted the Ombudsman's suggestion that it hold an Independent Review Panel. Consequently, the investigation was discontinued.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201303745 – January 2014
Mrs F complained that she had been in pain since a right hip replacement operation in 1999 and that despite numerous consultations and interventions, no diagnosis of the cause of her hip pain was made until 2011 when loosening of the right hip was identified. This was corrected by surgery which alleviated Mrs F's pain. Mrs F could not understand how this was not diagnosed sooner. Had it been recognised, it could have been corrected at a much earlier stage and saved Mrs F years of pain and mobility difficulties. The Health Board, in its response to her complaint, stated that there had been no evidence that the hip joint had loosened prior to 2011.

The Ombudsman sought clinical advice on Mrs F's complaint. The adviser noted that this was a complex case. He found no evidence from the records to indicate that anything went wrong with the initial hip replacement operation and all reasonable investigations into the cause of Mrs F's pain were done. All bone scans and x-rays prior to 2007 showed no signs of infection or loosening in the hip joint.

However, an x-ray in 2007 indicated loosening of the hip joint and this was missed by the treating team. In addition, an x-ray in 2010 showed loosening of the hip joint and change in orientation of the cup but this was wrongly reported. The adviser concluded that there was evidence of loosening of the hip joint from 2007 onwards but this was not followed up. This represented substandard care.

The Health Board accepted the adviser's findings and, on that basis, agreed to contact Mrs F to arrange redress in the form of an apology and financial compensation for the additional time that Mrs F was in pain.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201305494 – January 2014
The main aspect of Ms X's complaint was regarding the care and treatment her late mother received during her admission to Withybush General Hospital in November 2011 and January 2012. Ms X raised these concerns with the Health Board in a letter of complaint via the Community Health Council on 22 January 2013. However, although Ms X received a number of holding letters, she was yet to receive a final response from the Health Board.

The Ombudsman's office contacted the Health Board, which acknowledged the delay in providing Ms X with a final response. It also agreed to apologise for the prolonged delay and to provide Ms X with a final written response by an agreed date.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201304026 – November 2013
Mrs A complained to the Health Board following treatment in hospital. After receiving a response to the complaint, Mrs A attended a meeting to discuss outstanding concerns. Mrs A had yet to receive a copy of the notes of the meeting, and was dissatisfied with the delay. The Ombudsman's office contacted the Health Board, who advised that the notes were being transcribed and that a copy would be sent to Mrs A by the end of November.

Hywel Dda Health Board – Appointments/admissions/discharge and transfer procedures
Case reference 201303745 – November 2013
Mrs H complained about the length of time the Health Board had taken to respond to the further concerns which she raised in her letter dated 6 February 2013, which had followed the Health Board's original response to her complaint in January 2013.

Following consideration of the complaint, the Ombudsman noted that the Health Board had failed to provide its further response in a timely manner, or to inform Mrs H of the progress being made to do so. The Ombudsman's office contacted the Health Board to discuss the matter, and the Health Board agreed to provide Mrs H with its written response and to apologise for the delay.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201302598 – November 2013
Ms A complained to the LHB about the standard of care she received. The LHB did not investigate all her concerns. Ms A has since raised further complaints. The LHB has agreed to appoint an independent investigator to establish Ms A's outstanding concerns and investigate.

Hywel Dda Health Board – Continuing care
Case reference 201302230 – November 2013
Mrs E complained that the Independent Review Panel ("IRP") which considered an application for Continuing NHS Health Care funding ("CHC funding") for her late husband's care in February 2013 concluded that Mr E's care needs did not meet the criteria for CHC funding.

The investigation considered whether all obvious, appropriate and relevant clinical facts were established by the Health Board's assessment. Was there evidence that an appropriate clinically-led discussion of the impact and interaction of relevant key clinical facts took place to inform the decision process? Did the final decision adequately present (summarise) and take account of the conclusions of the clinically-led discussion? Were all the expected eligibility tests applied, and were the Health Board's conclusions about them clinically reasonable in light of the facts that were established?

The Ombudsman concluded that there were flaws in the way the IRP considered Mrs E's application. The Health Board accepted my recommendation that it should convene a fresh Panel to undertake a Retrospective Review. Therefore the investigation was discontinued.

September 2013 – Clinical treatment in hospital – Hywel Dda Health Board
Mr A complained about the length of time the Health Board had taken to complete its investigation into his complaint. Following consideration of the complaint, the Investigating Officer noted that Mr A had made the original complaint in September 2012. It was also noted that the Health Board had written to Mr A to explain that the matters raised in his correspondence would be subject to a thorough investigation. However, the Health Board also advised Mr A that the investigation process for serious/complex concerns could take far longer to complete. The Health Board gave its reassurance that the investigation report would be provided to Mr A in May 2013.

Following contact from the Ombudsman's office, the Health Board agreed to provide Mr A with a written response within five working days.
Case reference 201301906

August 2013 – Complaints-handling – Hywel Dda Health Board
Mr A complained about his difficulty accessing services at the NHS Dental Practice he usually attended. He was also dissatisfied with the Health Board's response to his concerns about the matter.

On receiving the complaint, the Ombudsman's office contacted the Health Board who agreed to provide Mr Jones with a more robust response to the concerns that he had raised in accordance with the NHS complaints procedure.
Case reference 201301405

May 2013 – Clinical treatment in hospital – Hywel Dda Health Board
Mrs Y complained of delay in treating her father, Mr S, following a referral from his GP. Mr S had a head lesion, initially thought to be a cyst, which was eventually diagnosed as a lymphoma.

The Ombudsman found that it took 6-8 weeks longer than was reasonable for Mr S to be seen in dermatology, although his case was marked as 'urgent'. Once seen, overall, the management of his condition in that department was reasonable. The Health Board agreed to settle the complaint by:

- apologising and making a payment of £750 for the identified delay;
- reminding staff of the need to note in medical records when lymph nodes had been examined and the result;
- taking suitable action to address waiting times for urgent cases.

Case reference 201202152

April 2013 – Patient list issues – Hywel Dda Health Board
The complainant was unhappy with the health care treatment he has received as a patient. The complainant was also unhappy that the complaint response he received from the Health Board contained numerous inaccuracies. The Health Board agreed to the complainant's letter to the Ombudsman as a new complaint, and respond to him accordingly. The complainant was told that he could make a fresh complaint to the Ombudsman if the new investigation failed to resolve his concerns.
Case reference 201300025

April 2013 – Clinical treatment in hospital – Hywel Dda Health Board
Mr N complained that he was yet to receive a response to his letter of complaint. Following contact from my office, the Health Board agreed to send Mr N its interim response.
Case reference 201300074