Our ref: MG/jm
Ask for: James Merrifield

Your ref:
01656 644 200

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

Mr Elwyn Price-Morris
Chief Executive
Welsh Ambulance Services NHS Trust
Ambulance Trust Headquarters
HM Stanley Hospital
St Asaph
Denbighshire
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Dear Mr Price-Morris

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 Welsh Ambulance Services NHS Trust.

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 Trust, my office received fewer complaints in 2013/14 compared to 2012/13 Not surprisingly in view of the nature of your Trust's service, the the largest single area of complaint is 'ambulance services'. My office has investigated more complaints this year, compared with last year, and has issue one 'upheld' report and two 'not upheld' reports. It is disappointing to note that all responses from your Trust were received more than five weeks after 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, Welsh Ambulance Services NHS Trust

Appendix

Explanatory Notes

Sections A and B provide a breakdown of the number of complaints against Welsh Ambulance Services NHS Trust which were received and taken into investigated by my office during 2013/14. The tables also contain the figures for 2012/13.

Section C compares the number of complaints against Welsh Ambulance Service NHS Trust received by my office during 2013/14, with the equivalent figures for 2012/13. These figures are broken down into subject categories.

Section D compares the number of complaints against Welsh Ambulance Services NHS Trust which were received and taken into investigation by my office during 2013/14, with the equivalent figures for 2012/13.

Section E compares the complaint outcomes for Welsh Ambulance Services NHS Trust during 2013/14, with the equivalent outcomes for 2012/13. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section F illustrates the response times for those complaints which were commenced and concluded during 2013/14. Where no response times have been recorded, the graph contains an illustration of the average response times for health bodies, and the average for all public bodies in Wales during the same period.

Finally, Section G contains the summaries of all reports issued in relation to the Welsh Ambulance Services NHS Trust during 2013/14.

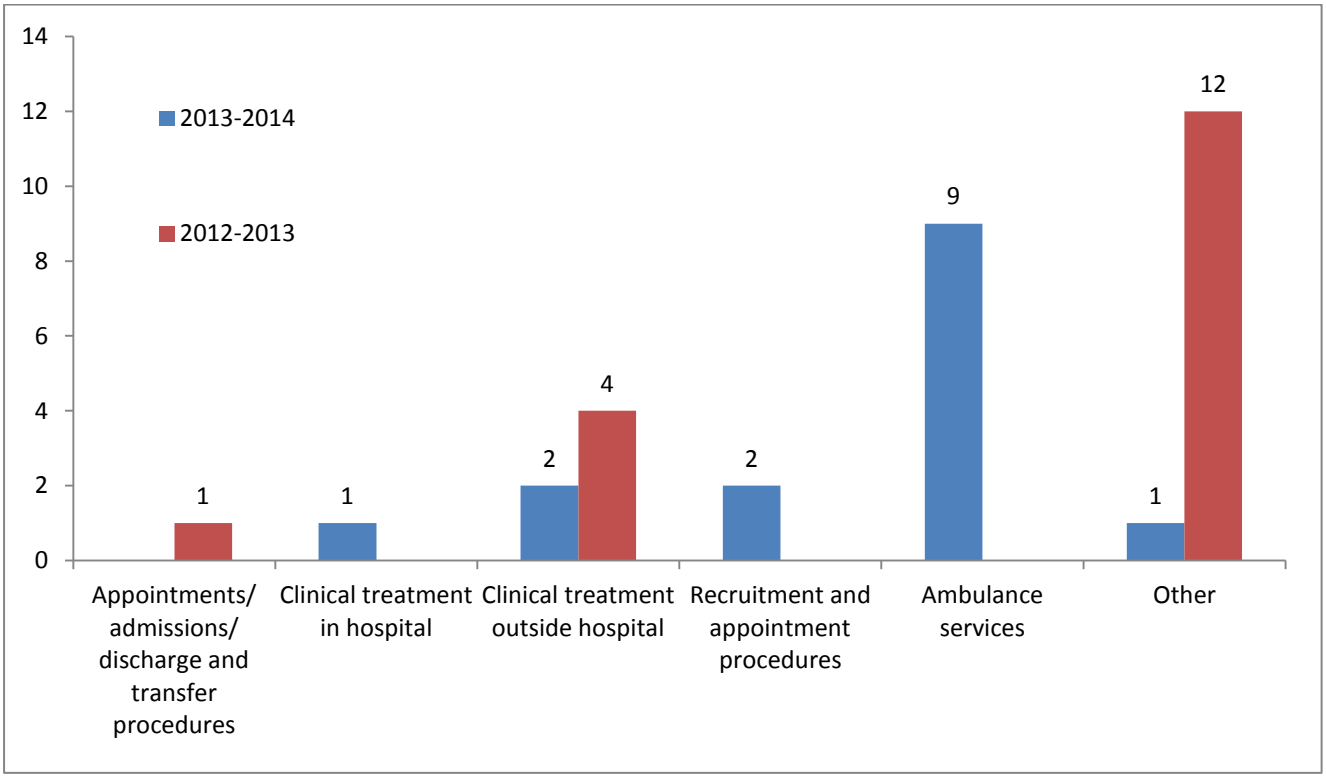
A: Complaints received by my office

Subject	2013/14	2012/13
Appointments/admissions/discharge and transfer procedures	0	1
Clinical treatment in hospital	1	0
Clinical treatment outside hospital	2	4
Recruitment and appointment procedures	2	0
Ambulance services	9	0
Other	1	12
TOTAL	**15**	**17**

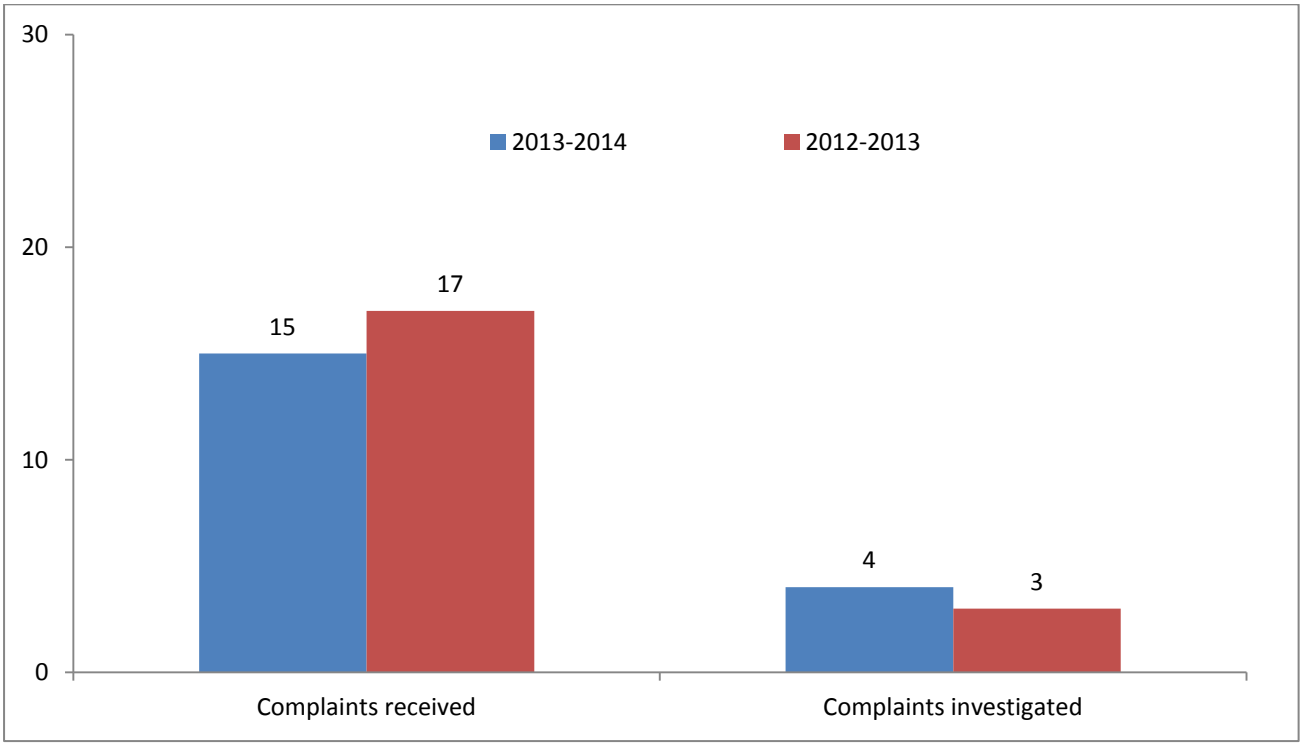
B: Complaints taken into investigation by my office

	2013/14	2012/13
Number of complaints taken into investigation	4	3

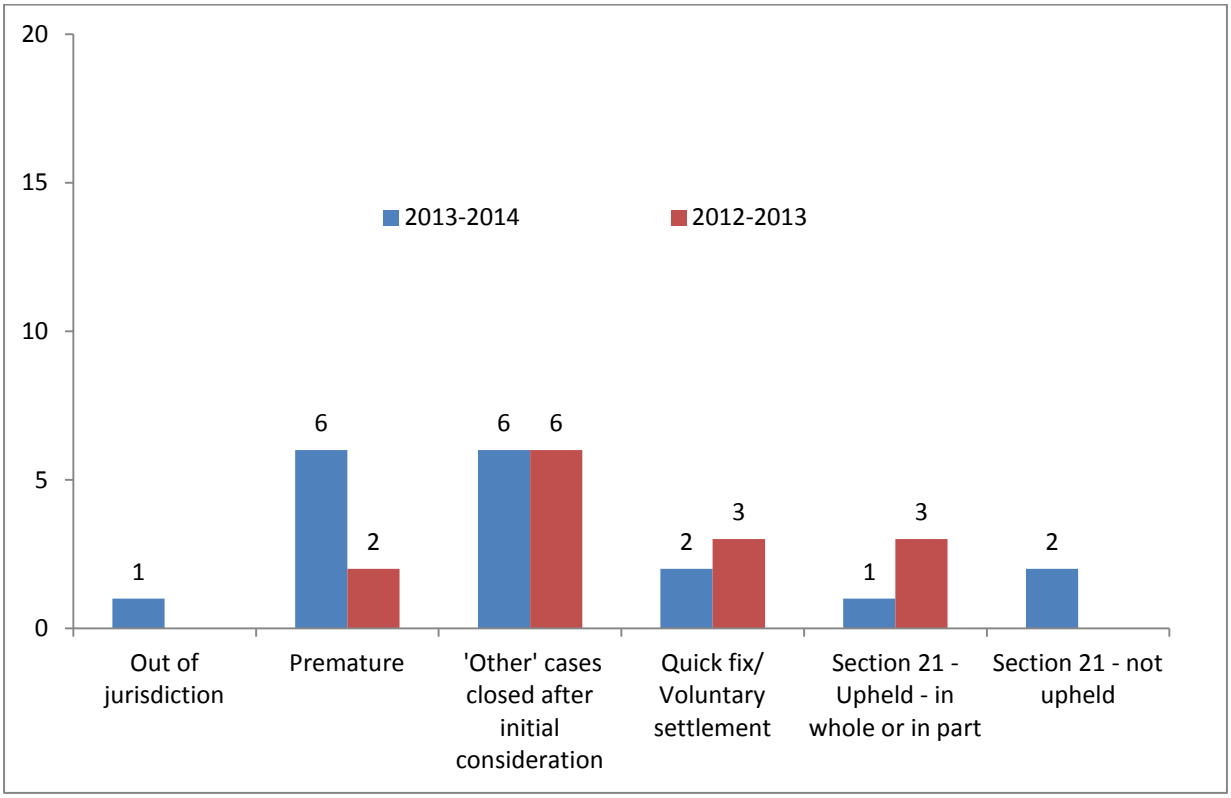
C: Comparison of complaints by subject category



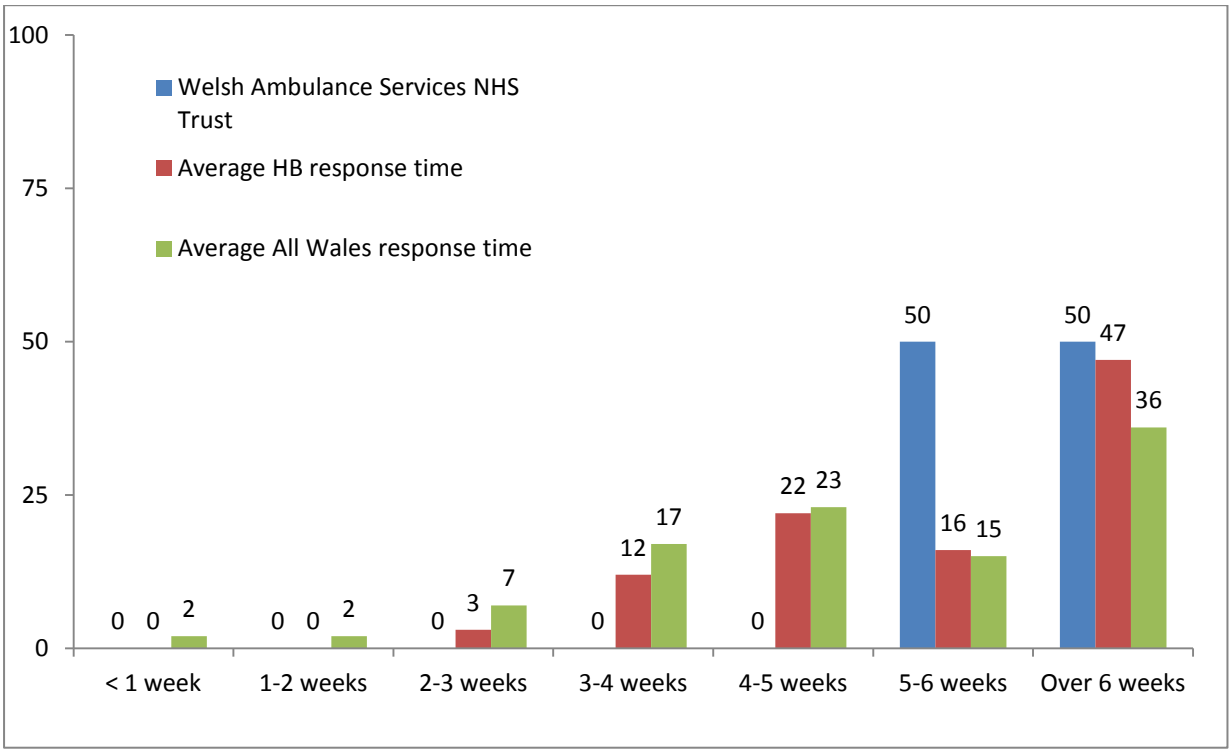
D: Comparison of complaints received and taken into investigation during 2013/14 with 2012/13 figures



E: Comparison of complaint outcomes during 2013/14 with 2012/13 figures



F: Comparison of Welsh Ambulance Service NHS Trust's times for responding to requests for information with average for health bodies and All Wales response times, 2013/14



G: Summaries

Upheld

May 2013 – Ambulance services – Welsh Ambulance Services NHS Trust
Mrs E complained about the Welsh Ambulance Services NHS Trust's ("the Trust's") response to a 999 call that she made about her mother, Mrs M. She suggested that its categorisation of this call, as neither serious nor life threatening, was unreasonable given the information that she conveyed about the seriousness of Mrs M's condition. She indicated that she knew, at the time of her call, that a clinical telephone assessment ("CTA") would not help Mrs M. She implied that the Nurse Adviser, who completed the CTA, did not appreciate the urgency of her call. She suggested that the Trust dispatched the wrong emergency vehicle. She complained that this vehicle, and the second one dispatched, took too long to arrive. She was also dissatisfied with the Trust's complaint handling.

The Ombudsman considered that the Trust initially categorised Mrs E's 999 call correctly given the information provided. He also judged that it deployed the correct emergency vehicle and sent it at the appropriate speed because of the categorisation, that it gave to her call, following the CTA. He also considered that the delay in the arrival of the second emergency vehicle was unavoidable. However, he concluded that the Trust's categorisation of Mrs E's call, after the CTA, was incorrect. He said that the Trust should have categorised it as one that required immediate intervention at that stage. He considered that the rapid response, associated with such intervention, was unlikely to have altered the outcome for Mrs M but noted that it would have reduced her suffering. He partly upheld the response element of Mrs E's complaint. He said that the Trust took too long to address Mrs E's complaint. He also noted that it did not audit the transfer call, made by the Nurse Adviser, following the CTA, as part of its complaint investigation. He partly upheld the complaint handling aspect of Mrs E's complaint.

He recommended that the Trust should apologise to Mrs E for the failings identified. He asked it to amend its Assessment Guidelines and to ensure that its learning programme for its Nurse Advisers addresses the issues raised by this investigation. He recommended that it should give him a copy of the request that it intends to make, to the International Academy of Emergency Dispatch, because of this investigation. He asked it to update him regarding the progress that it has made in terms of enabling its Nurse Advisers to influence the level of emergency response required. He recommended that it should give him a copy of its transfer call audit tool. The Trust agreed to comply with all of these recommendations.
Case reference 201200171

Not Upheld

Cardiff and Vale University Health Board & Welsh Ambulance Services NHS Trust – Clinical treatment in hospital
Case references 201203928 & 201205014 – Reports issued November 2013
Mr G complained about his mother's care (Mrs W) and management in what were her final days. He had a number of complaints, including as follows against the Health Board: a District Nurse (DN) had without his consent administered Mrs W with Hyoscine (a drug given in palliative care to dry up noisy chest secretions that can be

distressing for both patient and relatives), when he was not present, and Mrs W had suffered a fit necessitating her admission to hospital; Mrs W was moved overnight to a ward so that he did not know where she was the next morning and staff were initially unable to tell him; he was asked to leave the ward on arrival and told his mother was stable; and having gone home he was denied the opportunity of being with Mrs W when she passed away a short while later.

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

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

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

Welsh Ambulance Services NHS Trust – Ambulance services
Case reference 201201996 – Report issued October 2013

Mr and Mrs M complained that an ambulance was not sent when they telephoned 999 when a relative, Mr S, became suddenly very ill with severe stomach pains and vomiting. Their call was categorised as a 'green' call and referred for a telephone nurse assessment. They ended up driving Mr S to the local A&E department. They felt that the whole process had taken too long. Mr S was subsequently diagnosed with severe pancreatitis and spent several months in hospital.

The Ombudsman found no failing by the Ambulance Trust. On the basis of the information given during the call about Mr S's condition, the call was appropriately categorised as there were no symptoms to indicate that immediate intervention to save life was required. The telephone nurse assessment was quite lengthy, but it was

important that this was thorough in order to rule out any immediately life threatening condition. Mr S was clearly unwell and did need prompt medical assessment; however his condition did not need immediate life saving intervention. There was no treatment which a paramedic could have administered to Mr S other than pain relief. It was acknowledged that Mr and Mrs M found driving Mr S to A&E a stressful experience, but, given their location and that they were with their car at the time, this would have been the quickest means of transporting Mr S there. The Ombudsman did not uphold the complaint.

Quick fixes and Voluntary settlements

April 2013 – Ambulance services – Welsh Ambulance Services NHS Trust
Mr and Mrs W complained that the ambulance they called whilst their daughter was fitting, took 44 minutes to arrive at their home. On receiving the complaint, my office contacted WAST which said it had not received the recent letter. WAST agreed to respond to the letter within the next 30 working days.
Case reference 201300296

Roads and Transport

Quick fixes and Voluntary settlements

June 2013 – Other – Welsh Ambulance Services NHS Trust
Mrs D complained about the Welsh Ambulance Services NHS Trust ("the Trust"). She said that on 24 November 2012, because her father was having difficulty breathing, she rang 999 for an ambulance. Mrs D said that during the 999 call the call handler continually asked her "silly" questions. She also said that she made the call at 7:55pm but the ambulance did not arrive until 8:35pm.

The Trust was notified that I intended to start an investigation. On 24 May 2013, the Trust offered to try and resolve the complaint. It offered to meet with Mrs D at Trust headquarters. The Trust said that it would give Mrs D a demonstration of the Trust's systems in action and an explanation of how timings are recorded in relation to calls received. During the visit Mrs D would also be able to listen, with the support of trained staff, to the 999 call that was made on 24 November. The Trust agreed to Mrs D's request that a paramedic who responded to her 999 call could be included in the visit.

Mrs D agreed that the action promised would resolve her complaint. Therefore, my office concluded that the action the Trust said it would take was reasonable. Accordingly, the investigation was discontinued. Mrs D was advised that she could return her complaint to this office if the action promised by the Trust failed to materialise or proved to be unsatisfactory.
Case reference 201300013