Our ref: MG/jm
Ask for: James Merrifield

Your ref:
01656 644 200

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

Ms Allison Williams
Chief Executive
Cwm Taf University Health Board
Dewi Sant Hospital
Albert Road
Pontypridd
Rhondda Cynon Taff
CF37 1LB

Dear Ms Williams

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 Cwm Taf University Health Board.

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

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

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

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

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

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

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

In reference to your Health Board, my office has received the same number of complaints, but investigated a lower number, compared with 2012/13. Whilst the number of complaints relating to 'clinical treatment in hospital' decreased compared with last year, there were noticeable increases in the numbers of complaints relating to 'appointments, admissions, discharges and transfer procedures' and 'complaint-handling'. Whilst I am pleased to note that I did not issue any Public Interest Reports against your Health Board, you should note an increase in the number of 'upheld' reports issued, which is also above the average. It is also concerning to note that three-quarters of your Health Board's responses took more than five weeks.

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

Yours sincerely

Professor Margaret Griffiths
Acting Ombudsman

Copy: Chair, Cwm Taf 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.

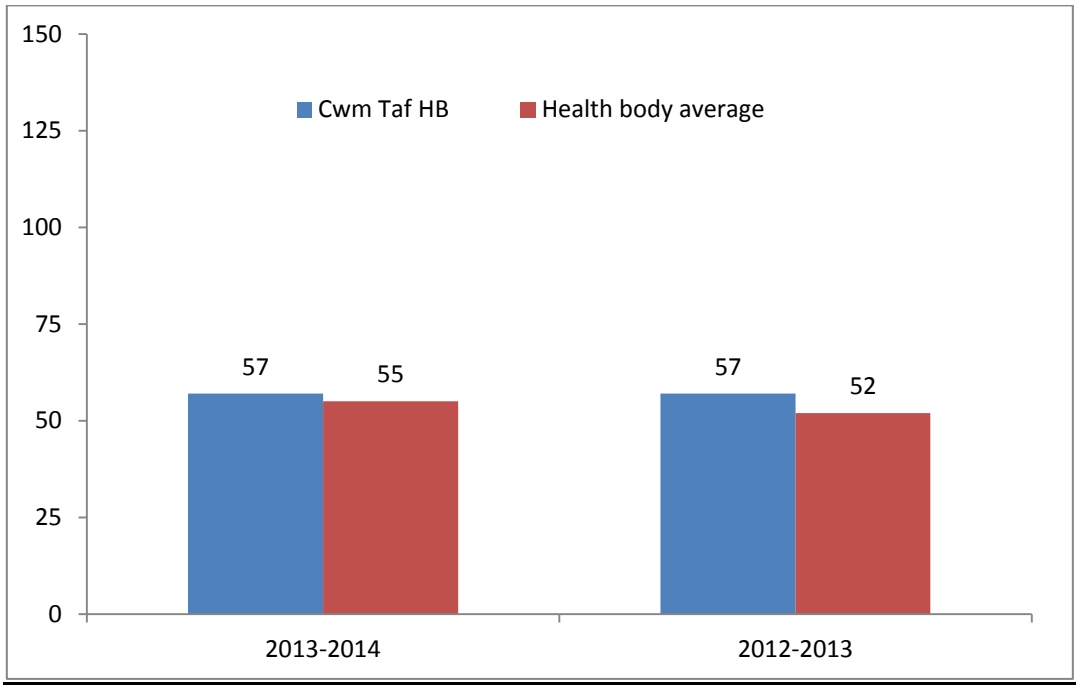
Section E compares the number of complaints against the Health Board which were taken into investigation by my office in 2013/14, with the average for health bodies (adjusted for population distribution) during the same period.

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

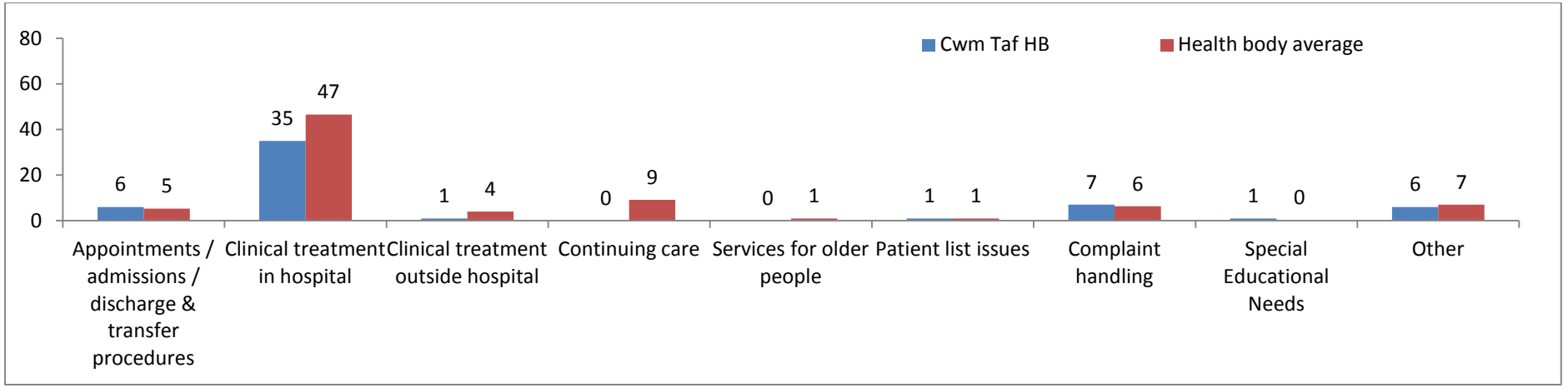


B: Complaints received by my office

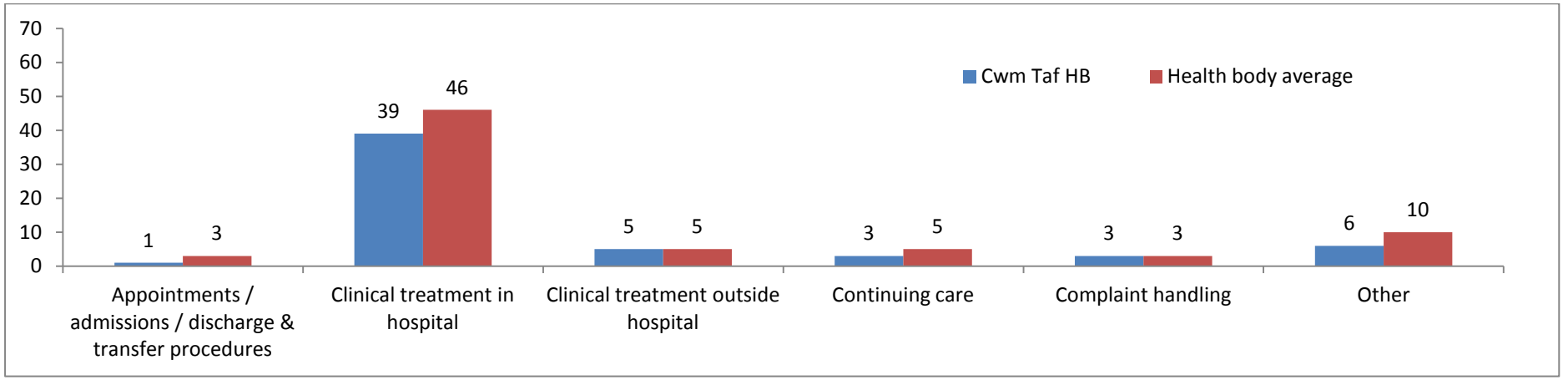
Subject	2013/14	2012/13
Appointments/ Admissions/ Discharge and transfer procedures	6	1
Clinical treatment in hospital	35	39
Clinical treatment outside hospital	1	5
Continuing care	0	3
Patient list issues	1	0
Complaint-handling	7	3
Special Educational Needs	1	0
Other	6	6
TOTAL	**57**	**57**

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

2013/14



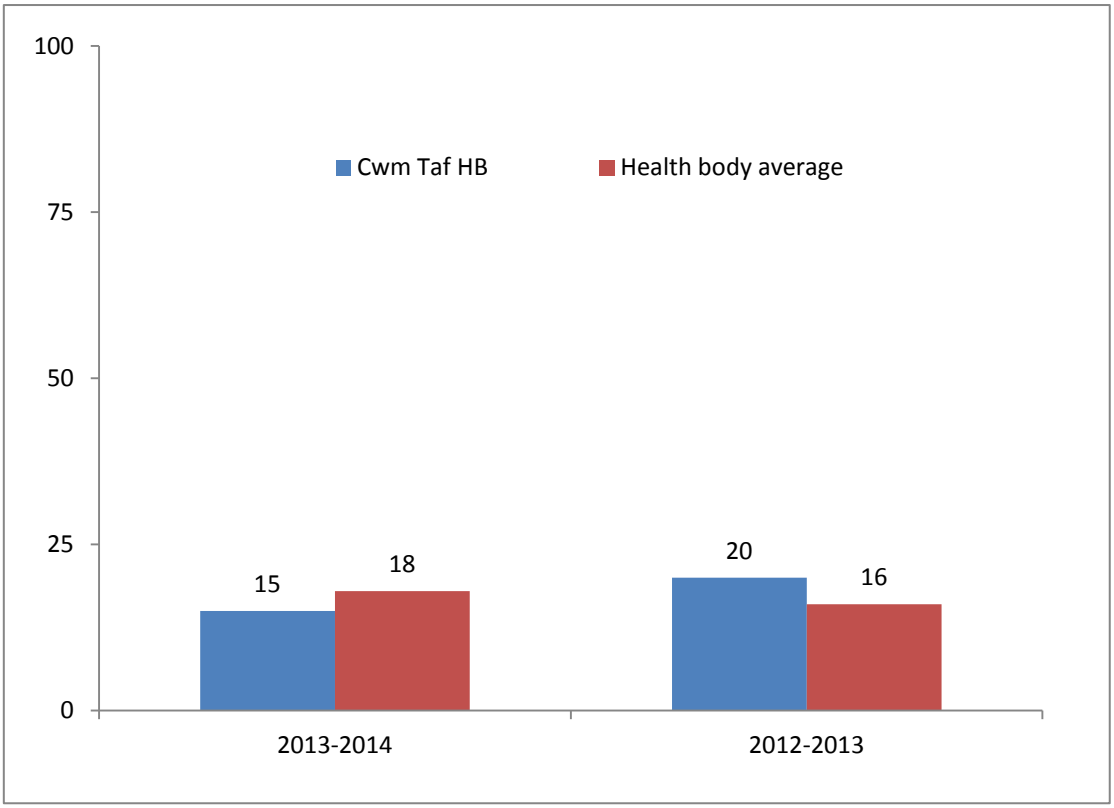
2012/13



D: Complaints taken into investigation by my office

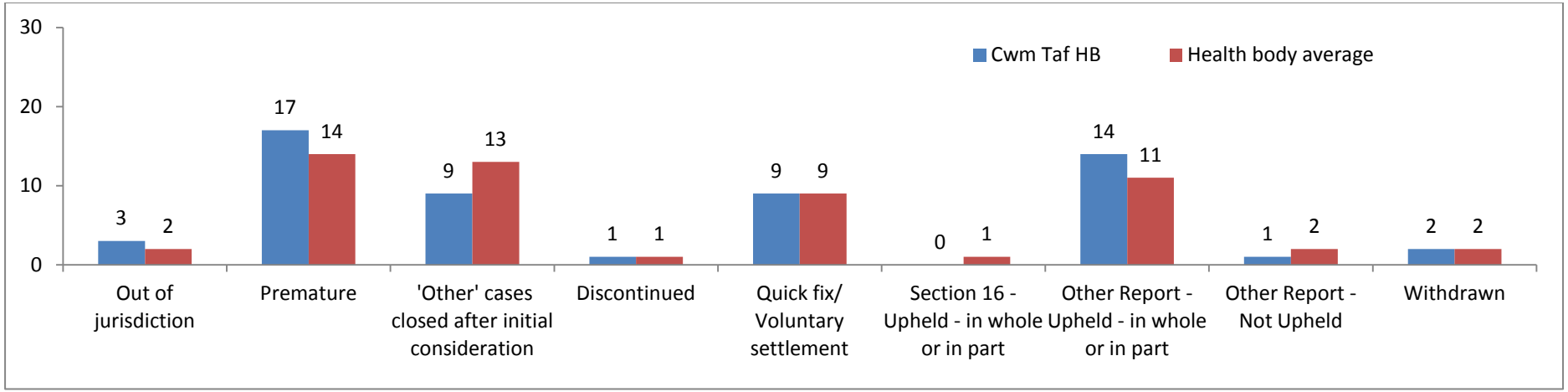
	2013/14	2012/13
Number of complaints taken into investigation	15	20

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

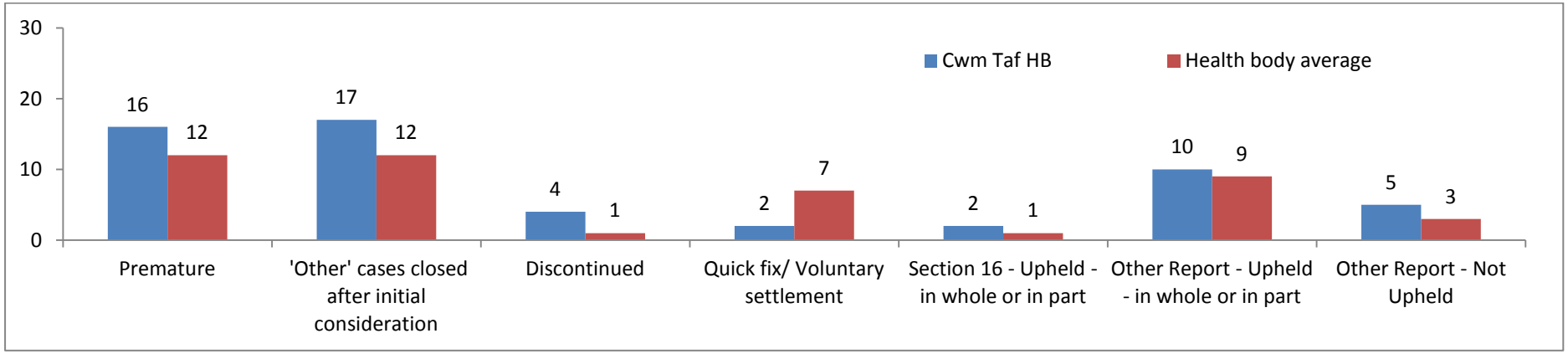


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

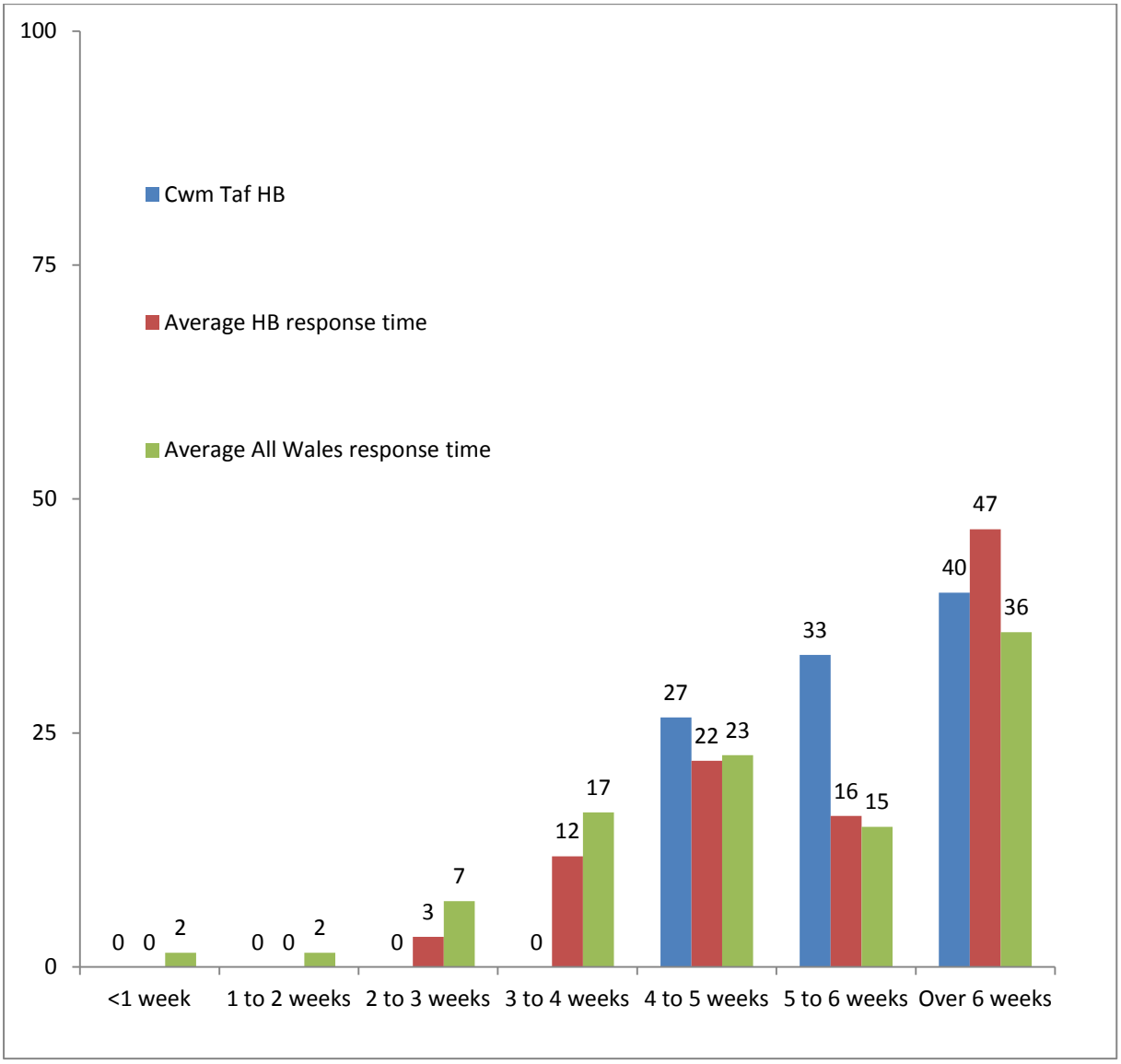
2013/14



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

Upheld

Cwm Taf Health Board & Betsi Cadwaladr University Health Board – Other
Case reference 201204407 & 201204700 – Reports issued February 2014
Mr F complained to the Ombudsman about the manner in which an Independent Hospital engaged with him in relation to the care and support being provided to his half brother, Mr S. The care for Mr S was commissioned by the Welsh Specialist Services Committee (WHSSC). Whilst Mr F raised no concerns about the quality of the care being provided to Mr S, he complained that the Independent Hospital had failed to recognise him as Mr S's nearest relative; had placed obstacles in his way as he tried to provide support and assistance to Mr S; had undertaken a mental capacity assessment in a flawed manner; and with the intention of preventing him from having access to Mr S's medical records. They were also concerned about the lack of advocacy support provided to Mr S and about discrepancies and omissions in Mr S's clinical notes.

The Ombudsman found that staff at the Independent Hospital had failed to communicate appropriately with Mr F, and that, having refused to recognise Mr F as Mr S's nearest relative, the Independent Hospital had then failed to undertake the appropriate enquiries to identify the nearest relative and failed to engage appropriately with Mr S's family and other professionals in that regard. The Ombudsman found that the Independent Hospital had failed to provide Mr S with adequate advocacy and that there were flaws in the mental capacity assessment that it carried out in order to establish whether Mr S had the capacity to consent to allow his clinical records to be shared with Mr F. The Ombudsman also found failings in the record keeping practices of the Independent Hospital which, whilst not impacting on Mr S's care, did make the process of pursuing the complaint difficult for Mr F. The Ombudsman upheld all the above aspects of the complaint and made the following recommendations of the Independent Hospital and WHSSC:

That WHSSC:

a) satisfy themselves, before commissioning any further care from the Independent Hospital, that it has addressed the shortcomings highlighted in the report;
b) engage with any responsible LHBs to provide advice, where needed, on the support any patients receiving care at the Independent Hospital or their families should be receiving in accordance with relevant mental health legislation;
c) remind any care provider it commissions services form for the need to maintain contact with the relevant Care Co-ordinator in the patient's home locality;
d) considers whether their framework agreement is sufficiently robust in relation to the Mental Capacity Act.

That the Independent Hospital:

a) apologise and pay the complainants redress of £1,500.

That the Health Board, which manages the local mental health team responsible for Mr S's current care (Betsi Cadwaladr University Local Health Board):

a) engage positively with Mr S and Mr F and any relevant professionals to determine the identity of Mr S's nearest relative.

Cwm Taf Health Board – Clinical treatment in hospital
Case reference 201203947 – Report issued January 2014

Mrs X complained about the care and treatment provided to her late brother, Y, during his admission at Royal Glamorgan Hospital in March 2012. Mrs X considered that the care her brother received was below a reasonable standard and specifically raised issues about his medication, delays in the provision of nutrition, the nursing care received and a lack of communication with the family about Y's condition during the period. Y died in hospital twelve days after his admission; Mrs X considers that she and her family were not given crucial information about his condition which could have led to a more dignified passing for Y at home.

The Ombudsman concluded that the care and treatment provided to Y during the period of admission, including his medication, was generally of an acceptable standard. Nevertheless, the Ombudsman identified failings in respect of the delay in the completion of a dietetic assessment and provision of nutritional support for Y within the early stages of his admission. The Ombudsman also determined that there had been a failure to fully comply with National Guidance in respect of the end of life care discussions and arrangements. Whilst, the Ombudsman found evidence which was suggestive that information about Y's condition had been given to his family in a timely manner, it appeared that the communication was not as effective as it could have been. Whilst this was not identified as a failing, the Health Board was nevertheless asked to consider this as a matter for service improvement.

The Ombudsman recommended that the Health Board:

a) provide a written apology to Mrs X for the failings identified;
b) pays Mrs X £500 to recognise the distress caused by knowledge of the failings identified and £250 in respect of her time and trouble in pursuing this complaint;
c) review its procedure and provision for emergency feeding outside the times of its usual Dietetic Service;
d) provide this office with evidence of an analysis of Y's care, any action points and the outcome of the same;
e) Provide a copy of the final report of this investigation to all the staff involved with Y's care for reflection.

Cwm Taf Health Board – Clinical treatment in hospital
Case reference 201302513 – Report issued January 2014

Mrs A complained that her late mother, Mrs W, had complaint of cramps in her leg after treatment for a broken ankle. Mrs A said that at her mother's outpatient's appointments that her mother continued to complain about cramps and a throbbing in her leg. She was referred to physiotherapy but unfortunately passed away before her appointment.

Mrs A said her mother presented with the symptoms for DVT and she should have had a Doppler scan which would have saved her life. Her mother was not given a surgical stocking after her operation.

The Adviser said that Mrs A's symptoms were consistent with DVT, but, in this instance, they were equally consistent with her post operative progress. The Adviser said that, without the benefit of hindsight, there was insufficient evidence to justify a Doppler scan, which was a reasonable response. The Adviser said that there was no evidence for Mrs A to have had surgical stockings as well as her warfarin treatment. Mrs A's physiotherapy appointment had been within the prescribed time limit. In response to Mrs A's complaint, the Registrar said that Mrs W had complained of cramps which he had not recorded in the medical notes.

It was recommended that, within one month of this report, the Health Board should:

a) highlight to the Registrar the importance of recording patient's symptoms;
b) the Consultant surgeon to discuss this case with colleagues;
c) review the policy of administrating warfarin in preference to low molecular weight heparin.

Within two months of this report, the Health Board should:

a) forward the Orthopaedic Department's policy for the prevention of DVT in long term immobile patients including those in the community.

Cwm Taf Health Board – Clinical treatment outside hospital
Case reference 201203653 – Report issued January 2014
Mr P complained about his post-operative wound care by the District Nursing Service following a knee replacement. He said that the wound did not heal quickly because of poor and inconsistent care which resulted in a second operation to clean and re-stitch the knee.

The Ombudsman found that there were a number of fundamental shortcomings in Mr P's care. There were failings in wound care management because there was no initial assessment and overall care plan. Also, there were inconsistencies in the type of dressings applied and no recorded explanations for the changes. On two occasions the dressings were found to be inappropriate. The investigation was not helped by the standard of note keeping which was poor and incomplete.

Overall, although certain aspects of Mr P's complaint were upheld, the Ombudsman could not say with any certainty that the shortcomings directly delayed the healing process or that the outcome would have been any different had the shortcomings not occurred. The Health Board agreed to apologise to Mr P for the failings identified and to:

1) ensure systems were in place to require nursing assessments and treatment plans for longer term patients;
2) carry out audits to show this had been done;

3) put in place training for team members on record keeping and wound care management.

Cwm Taf Health Board – Clinical treatment in hospital
Case reference 201203378 – Report issued January 2014
Mr J complained about the inpatient care provided for his late mother, Mrs G, by Cwm Taf Health Board ("the Health Board"). He said that its assessment and management of her falls risk was lacking. He contended that it took too long to X-ray her right leg following a fall. He suggested that it gave her inadequate pain relief after this fall. He told us that it should have operated on Mrs G's fractured leg earlier. He said that its decisions to postpone this operation were unreasonable. He indicated that it should have told him that Mrs G had vascular dementia (A disruption in the brain's blood supply causes vascular dementia, which is a mental disorder) sooner. He also complained about its complaint handling because the first local resolution meeting was aborted and the Consultant Physician indicated, during the second meeting, that she would not change her practice.

The Ombudsman partly upheld Mr J's complaint because she considered that the Health Board delayed Mrs G's operation unreasonably and that its assessment and management of her falls risk was deficient. She also noted that it did not keep records of the first local resolution meeting and that some of the information, in the Chief Executive's letter to Mr J, was misleading. She recommended that the Health Board should:

a) write to Mr J to apologise for the failings identified;
b) ensure that it keeps records of all complaint-related meetings;
c) ensure that its management of hip fractures complies with relevant guidance;
d) provide training related to its Falls Procedure.

The Health Board agreed to comply with these recommendations.

August 2013 – Clinical treatment in hospital – Cwm Taf Health Board
Mr S complained on behalf of his wife Mrs S about the care and treatment provided to her when she was admitted to the maternity unit of a hospital operated by Cwm Taf Local Health Board. Mr S complained about the appropriateness of the decision taken to induce his wife and the subsequent care and treatment options followed by the staff in arranging the delivery of his son. Mr S raised concerns about the post delivery care provided to his wife and child. In addition Mr S expressed concern about the delay experienced in receiving a response to his complaint from the Health Board and the fact that his wife's patient records were misplaced.

The Ombudsman's investigation found that the clinical care provided to Mrs S's clinical care was both appropriate and reasonable. However, the investigation identified a distinct lack of communication with Mr S and Mrs S following the birth of their son. In addition the Ombudsman was critical of the approach taken by the Health Board in relation to the loss of Mrs S's patient records and the handling of the complaint.

The Ombudsman recommended that the Health Board apologise to Mr and Mrs S and make a payment of £500 in recognition of the failings identified in the report. In addition the Ombudsman asked the Health Board to review and where appropriate amend its Health Records Policies and any other policies which relate to the safeguarding of patient records.

Case reference 201202342

August 2013 – Clinical treatment in hospital – Cwm Taf Health Board

Mrs A and Mrs B complained about the care and treatment provided to their mother, Mrs C, during her two admissions to Royal Glamorgan Hospital on 6 and 23 November 2011. Sadly, Mrs C died in hospital on 29 November 2011. In particular, Mrs C's daughters said that the nursing staff failed to correctly administer pain medication and did not act upon their earlier requests to review their mother's feet discolouration. The family asked whether their mother should have been provided with intravenous antibiotics. They said that their mother's request for the immediate removal of her gallbladder was ignored. Finally, the family complained about the lack of information provided to their mother and to them about her condition during the admissions, in particular, during the discharge process on 14 November 2011. Mrs A and Mrs B said that at no time were the family informed that their mother's condition could be life threatening.

Having obtained professional advice on the nursing and clinical aspects of Mrs C's care, the Ombudsman partly upheld the complaint. The evidence confirmed that there were shortcomings in the administration of pain medication and management of Mrs C's feet discolouration. More significantly, the Ombudsman found that intravenous antibiotics were stopped at a time when they should have been continued and that Mrs C's discharge from hospital on 14 November 2011 was premature. However, the Ombudsman was unable to conclude that these shortcomings would have altered the sad outcome.

The Ombudsman recommended that the Health Board should:

- provide an apology to the family for the failings identified;
- make a payment of £2,000 in recognition of ongoing distress to the family;
- confirm that a review of the case had taken place and confirm what action had been taken to address the shortcomings identified;
- demonstrate how its current project dedicated to "patient flow" is improving bed waiting times at the Hospital.

Case reference 201202928

May 2013 – Clinical treatment in hospital – Cwm Taf Health Board

Mrs T complained about the manner in which the Health Board had prioritised an urgent GP referral for her husband Mr T to attend the endoscopy department. He was put on an urgent waiting list for an endoscopy, which was at that time around 10 weeks. After concerns raised by Mrs T about the length of the wait, Mr T's GP re-referred him two weeks later, describing the same symptoms, using the fast track procedure for patients with suspected cancer. These patients should initially be seen within 2 weeks. Mr T was subsequently diagnosed as having upper gastrointestinal (GI) cancer. Mrs T also complained about the manner in which the treatment decision was reached.

The Ombudsman found that there was sufficient information on the initial referral to indicate that Mr T had several of the common 'red flag' symptoms indicative of upper GI cancer. The Health Board failed to realise that the first GP referral should have been treated as an 'urgent suspected cancer' (USC) referral and Mr T should have been seen within 2 weeks. The Ombudsman therefore upheld this part of Mrs T's complaint. The Ombudsman found no shortcoming in the treatment decision.

The Ombudsman recommended that the Health Board should:

a) Apologise to Mr and Mrs T.

b) Review its processes to ensure that all GP referrals which contain the 'red flag' cancer symptoms (in line with NICE CG27) are identified and correctly prioritised as USC cases. The priority given should not rely solely on the type of form that is completed by the GP.

c) Review its endoscopy waiting list to ensure that other referrals have not been inappropriately classified as non-USC.

Case reference 201201345

May 2013 – Clinical treatment in hospital – Cwm Taf Health Board

Mrs N complained about Cwm Taf Health Board ("the Health Board") regarding her care at one of its hospitals and subsequent complaint handling. Mrs N said that she was poorly after an operation with symptoms of a severe infection. However, medical staff did not explain exactly what had caused her ill health and the information she had was confusing.

The Ombudsman upheld Mrs N's complaints. He found that her care was generally good but there were some temporary shortcomings concerning her care and the use of antibiotics. He considered that this might have contributed to a limited extent to her slow recovery. The Ombudsman also concluded that communications were poor and it was plausible that Mrs N had little idea why she had been so poorly. He also criticised complaint handling, which was slow and unhelpful. The Ombudsman made various recommendations including a total payment of £550 to reflect Mrs N's injustice and some de-briefing among relevant medical staff. The Health Board agreed to implement his recommendations.

Case reference 201202301

Not Upheld

September 2013 – Clinical treatment outside hospital – Cwm Taf Health Board
Mrs B's mother (Mrs C) agreed to undergo surgery for the amputation of over-riding toes. The surgery was carried out in a neighbouring Health Board under a waiting list management arrangement. Mrs C met the surgeon on the day of the surgery, and had one follow-up appointment with him ten days later when she was discharged. Mrs B complained that her mother had not been given adequate advice before the surgery, or sufficient support following it. She also complained about a delay in responding to the complaint.

The Ombudsman did not uphold the complaint. Although he considered it would have been better if Mrs C had been able to meet the surgeon beforehand, he concluded that she did have appropriate pre-surgery advice. He also found that there was no need for a package of support immediately following the surgery, and that the support she received subsequently from the orthotics department was appropriate. The delay in dealing with the complaint was not unreasonable in view of the fact that the response required input from the neighbouring Health Board.
Case reference 201204521

Quick fixes and Voluntary settlements

Cwm Taf Health Board – Complaints-handling
Case reference 201304373 – November 2013
Mrs X and Mrs Y's were unhappy with a complaint response received from Cwm Taf Health Board in relation to the care received by their late father, Mr Z. On receipt of the complaint, the Ombudsman's office contacted the Health Board, which agreed to send a further response to Mrs X and Mrs Y.

Cwm Taf Health Board – Clinical treatment in hospital
Case reference 201303527 – October 2013
Mrs H complained that she had received a letter from the Health Board stating it was not able to address a number of outstanding points of her complaint in writing, as had been agreed, but instead considered that a meeting would be a better way forward. Mrs H also stated that she felt the Health Board was not listening to her requests not to attend a meeting with it.

The Ombudsman's office contacted the Health Board, who advised that a response had been sent to Mrs H recently, which explained the Health Board's position on the outstanding points of the complaint.

Cwm Taf Health Board – Complaint-handling
Case reference 201303460 – October 2013
Mrs X complained that she had not received a response from the Health Board after making a complaint about the way her late father was treated during his stay in Hospital. The Ombudsman's office contacted the Health Board, which agreed to send its final response by a specified date.

Cwm Taf Health Board – Complaint-handling
Case reference 201303706 – October 2013
Mr E complained that he had not received a final response to his complaint, which he originally made to the Health Board in March 2013. The Ombudsman's office contacted the Health Board, which stated that it would send a full response by an agreed date.

August 2013 – Complaint-handling – Cwm Taf Health Board
Mrs L contacted my office because she was unhappy that a complaint against the Health Board had been ongoing for approximately 14 months with no response. Following contact from the Ombudsman's office, the Health Board confirmed that a response had recently been posted to Mrs L.
Case reference 201302536

April 2013 – Clinical treatment in hospital – Cwm Taf Health Board
Mrs O complained that after receiving a report, she became aware that her late husband may have been alive on arrival at the Royal Glamorgan Hospital on 2 September 2011. Mrs O attended a meeting with the Health Board in order to address her concerns. Mrs O was informed by the Health Board that this was a mistake. However, Mrs O says she asked to be informed about who made the entries on her late husband's notes along with an explanation to why this happened.

At the time of contacting the Ombudsman, Mrs O had not received any information from the Health Board.

Following contact from my office, the Health Board agreed to share further information with Mrs O, including a full explanation as to why such entries/data was noted on her late husband's hospital notes, which indicate he may have still been alive upon arrival at the hospital. The Health Board agreed to write to Mrs O within three weeks.

Case reference 201204727

Education

Quick fixes & voluntary settlements

Cwm Taf Health Board – Special Educational Needs
Case reference 201303731 – March 2014

Mr & Mrs A complained about the Health Board's decision to impose sanctions against them following incidents of alleged verbal aggression towards Health Board staff at meetings to consider their son's special educational needs provision. Mr & Mrs A said that the sanctions made it impossible for them to represent their son's interests. As a consequence they had withdrawn their consent for the Health Board to undertake any further assessment of their son's needs and he had been without therapy for a number or months.

The Ombudsman identified a number of administrative failings in relation to the provision of assessment reports, the application of its Code of Conduct and complaint handling. The Ombudsman contacted the Health Board with a view to reaching an early resolution of the complaint. The Health Board agreed to:

a) apologise to Mr & Mrs A for the administrative failings identified;
b) attend independent dispute resolution with Mr & Mrs A;
c) in the event that Mr & Mrs A disagree with the professional opinion of the Health Board's therapist, offer a second independent NHS opinion;
d) make arrangements for any missing hours of therapy to be provided;
e) undertake a review of the terms of its Service Level Agreement with the Council;
f) process Mr & Mrs A's information request in accordance with the provisions of the Freedom of Information Act 2000.