Our ref: MG/jm
Ask for: James Merrifield

Your ref:
01656 644 200

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

Mr Simon Dean
Chief Executive
Velindre NHS Trust
Unir 2 Charnwood Court
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Dear Mr Dean

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 Velindre 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 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 five complaints in 2013/14, compared with two complaints in 2012/13. Of the complaints received, four complaints related to 'clinical treatment in hospital'. However, my office did not investigate any of these complaints. In reference to complaint outcomes, my office did issue one 'upheld' report during 2013/14. Finally, I would urge you to familiarise yourself with the enclosed summary to ensure that your Trust is aware of all relevant cases.

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, Velindre NHS Trust

Appendix

Explanatory Notes

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

Section C compares the number of complaints against Velindre 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 Velindre NHS Trust which were received and investigated by my office during 2013/14, with the equivalent figures for 2012/13.

Section E compares the complaint outcomes for Velindre NHS Trust during 2013/14, with the equivalent outcomes during 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 taken into investigation 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.

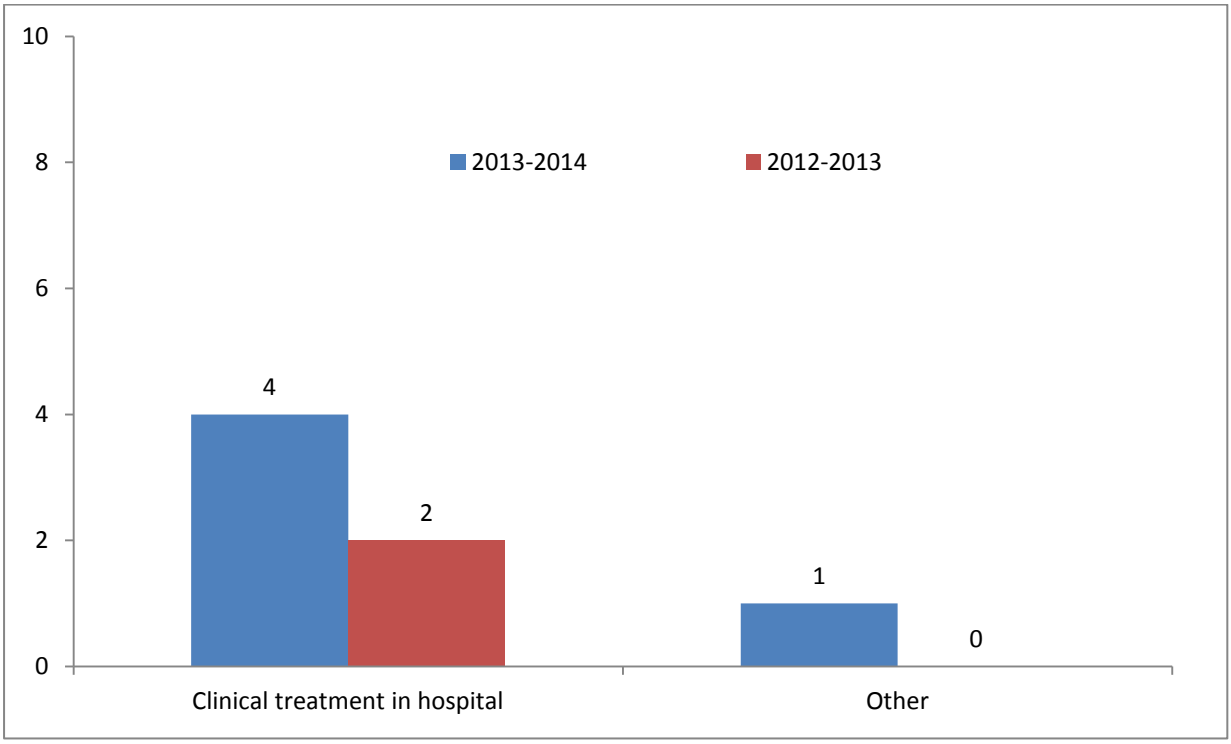
A: Complaints received by my office

Subject	2013/14	2012/13
Clinical treatment in hospital	4	2
Other	1	0
TOTAL	**5**	**2**

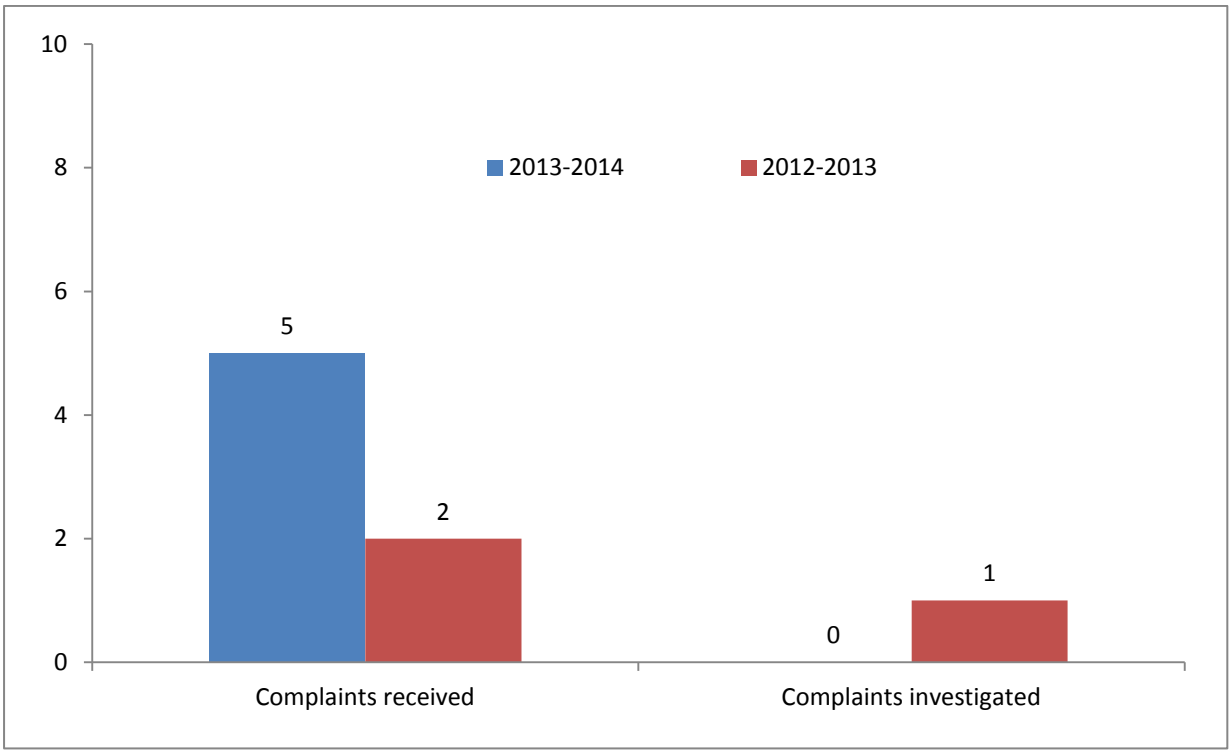
B: Complaints taken into investigation by my office

	2013/14	2012/13
Number of complaints taken into investigation	0	1

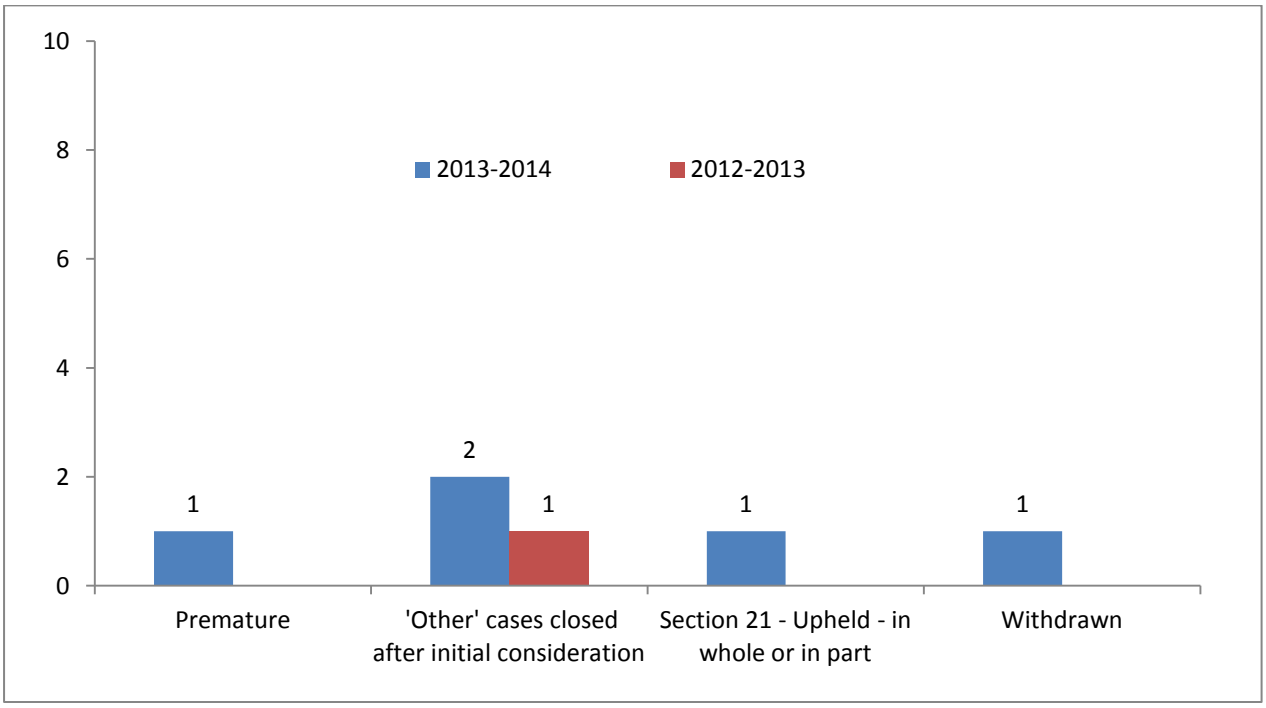
C: Comparison of complaints by subject category



D: Comparison of complaints received and investigated during 2013/14 with the figures for 2012/13

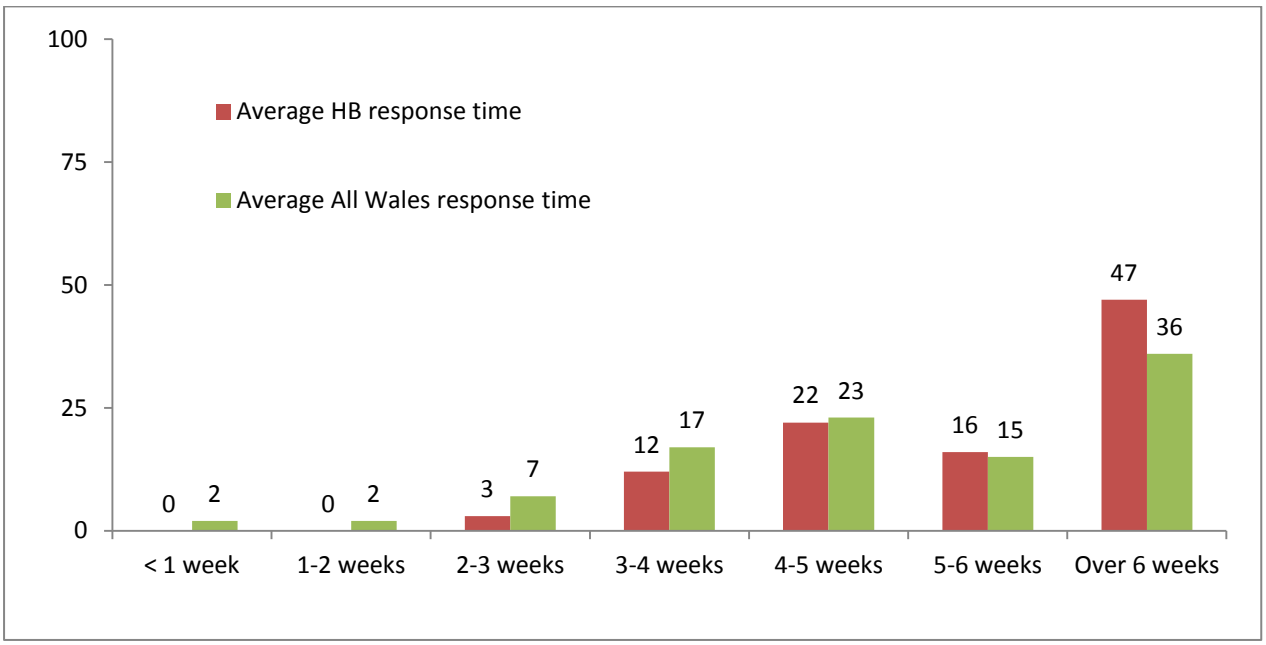


E: Comparison of complaints by outcome during 2013/14 with 2012/13 figures



F: Response times, 2013/14 (%)

Graph F relates to those complaints which were taken into investigation during 2013/14. As there were no complaints against Velindre NHS Trust which were taken into investigation during 2013/14, there are no response times for Velindre NHS Trust. However, we have included the average Health Board response times and the average response times for all bodies in Wales for your information.



G: Summaries

Upheld

Velindre NHS Trust – Clinical treatment in hospital
Case reference 201203816 – Report issued January 2014

Mrs C complained about the care provided for her late maternal grandmother, Mrs M, by Velindre NHS Trust ("the Trust"). Her complaint concerned the Trust's management of Mrs M's radiotherapy treatment (using radiation to kill cancer cells or to stop them from multiplying) and its side effects, its response to her breathlessness, and her nutritional and pressure ulcer-related care.

The Ombudsman partly upheld Mrs C's complaint. She considered that the Trust failed to seek specialist advice from Cardiff and Vale University Health Board promptly, to ensure that Mrs M's ongoing breathing difficulties were investigated appropriately, to comply with her dietary care plan and to complete her Food Record Charts ("FRCs") fully. She recommended that the Trust should:

a) write to Mrs C and Mrs L, Mrs C's mother, to apologise for the failings identified;
b) share the investigation report with staff members and discuss it in an appropriate forum;
c) revise its current care pathways to make sure that robust arrangements are in place to ensure that patients, with persistent breathing difficulties, are investigated in a timely manner;
d) formally remind staff members that they should always complete FRCs fully and record the provision and rejection of all nutritional supplements on them.

The Trust agreed to comply with these recommendations.