Our ref: PT/jm

Ask for: James Merrifield

Your ref:

01656 644 200

Date: 9 July 2013

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

Annual Letter 2012-2013

Following the recent publication of my Annual Report, I am pleased to provide you with the Annual Letter (2012-2013) for Welsh Ambulance Services NHS Trust.

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

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

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

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

In reference to your Trust, there has been a noticeable increase in the number of complaints received by my office. It has also been necessary to take three complaints into investigation during 2012/13, although this figure is fewer than 2011/12. The figures indicate that there were more cases closed as quick fixes or voluntary settlements compared with 2011/12, whilst there have also been fewer ‘upheld’ reports issued. It is disappointed to note that two thirds of responses to requests for information from my office were received more than five weeks after they were requested.

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

Yours sincerely

Peter Tyndall
Ombudsman

Copy: Chair, 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 2012-2013. The tables also contain the figures for 2011-2012.

Section C compares the number of complaints against Welsh Ambulance Service NHS Trust received by my office during 2012-2013, with the equivalent figures for 2011-2012. 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 2012-2013, with the equivalent figures for 2011-2012.

Section E compares the complaint outcomes for Welsh Ambulance Services NHS Trust during 2012-2013, with the equivalent outcomes for 2011-2012. 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 2012-2013. 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 2012-2013.

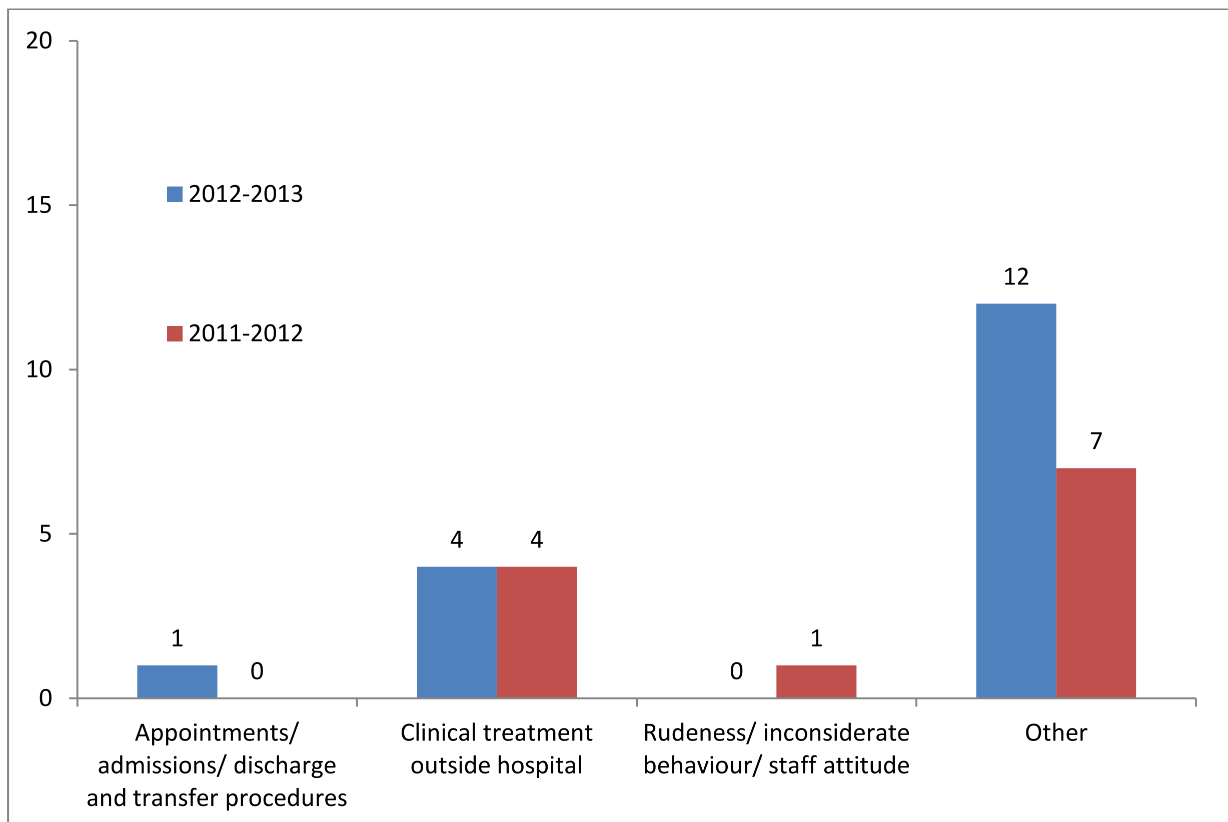
A: Complaints received by my office

Subject	2012-2013	2011-2012
Appointments/admissions/discharge and transfer procedures	1	0
Clinical treatment outside hospital	4	4
Rudeness/inconsiderate behaviour/staff attitude	0	1
Other	12	7
TOTAL	**17**	**12**

B: Complaints taken into investigation by my office

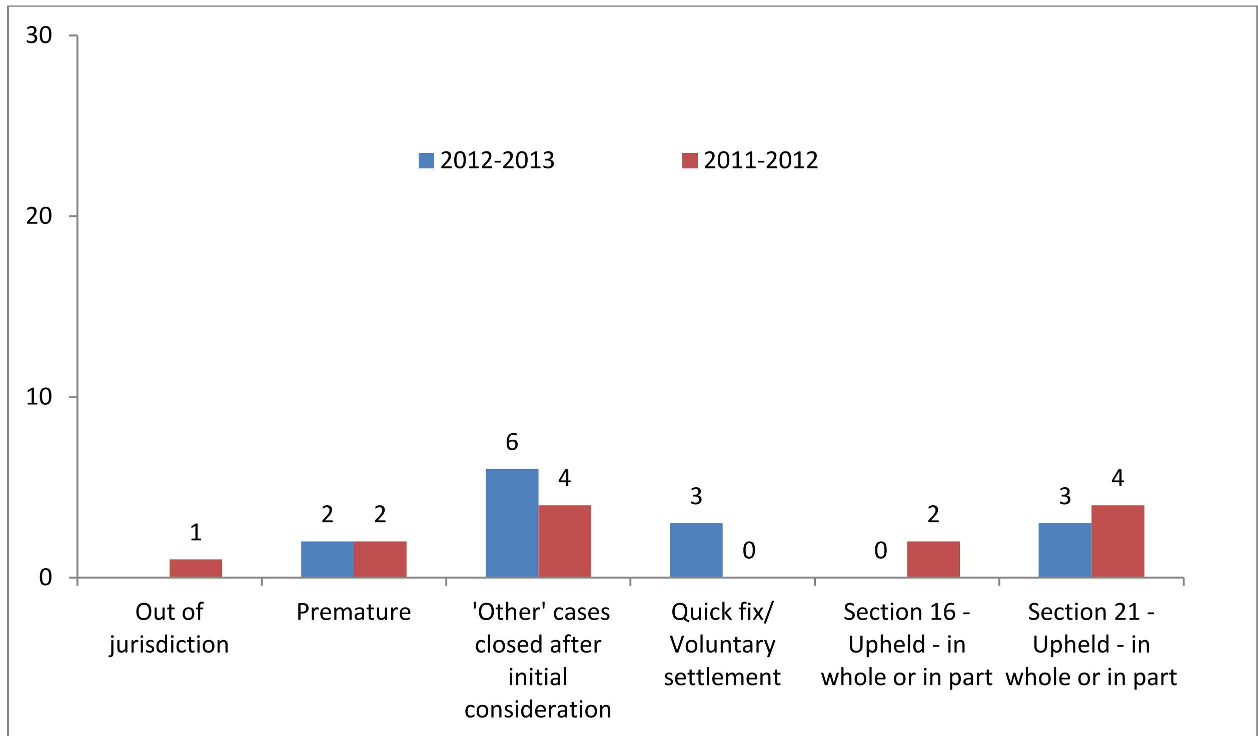
	2012-2013	2011-2012
Number of complaints taken into investigation	3	4

C: Comparison of complaints by subject category

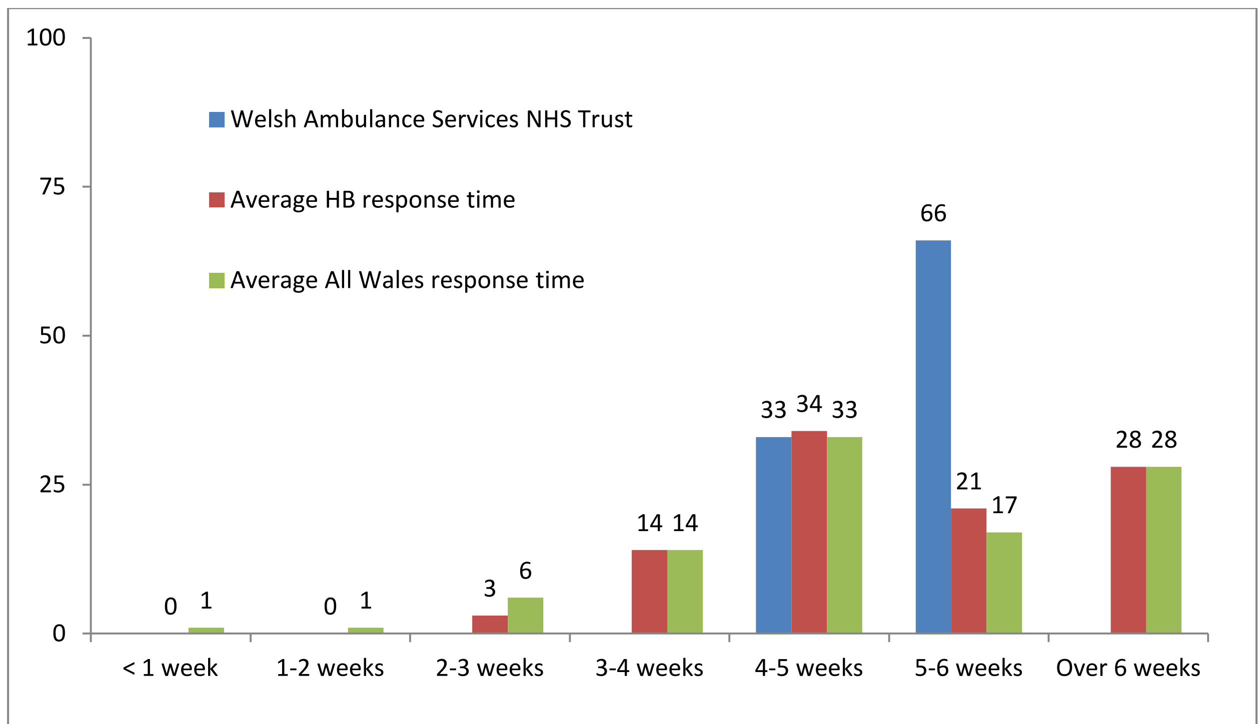


D: Comparison of complaints received and taken into investigation during 2011-2012 with 2011-2012 figures

E: Comparison of complaint outcomes during 2012-2013 with 2011-2012 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, 2012-2013



G: Report Summaries

Upheld

January 2013 – Other – Welsh Ambulance Services NHS Trust
Mr A complained that there was an unreasonable delay in an ambulance arriving after he dialled 999 when his father became ill in December 2011. The Ombudsman found that, due to human error, an ambulance was not dispatched until 41 minutes after Mr A's original call.

The Ombudsman upheld the complaint. He was satisfied that the action taken by the Trust to reduce the risk of this happening again was reasonable. He recommended that the Trust should provide further apologies to Mr A and his father and pay Mr A's father £500 in recognition of the distress he was caused through having to wait longer than necessary for the ambulance to arrive.
Case reference 201200999

November 2012 – Clinical treatment outside hospital – Welsh Ambulance Services NHS Trust
Miss J complained that there were delays in an ambulance being sent following a number of 999 calls she made on 3 January 2011 after her mother, Mrs J, became ill. She was also unhappy about the Welsh Ambulance Services NHS Trust's response to her formal complaint.

The Ombudsman found that Miss J's initial 999 call had been wrongly categorised as a Category B call (serious but not life-threatening) rather than Category A (immediately life-threatening). A second call made by Miss J was correctly categorised as Category A, but was incorrectly removed from the system as a duplicate call without the original call being upgraded. It was not until Miss J's third call that the call was correctly categorised and the original categorisation removed from the system. It was not until 53 minutes after Miss J's initial 999 call that an ambulance arrived at Mrs J's home. Sadly, despite the best efforts of the ambulance crew, and members of the public who had performed CPR in the meantime, Mrs J died at the scene.

The Ombudsman acknowledged that the Trust was experiencing high demand for its services on that day. However, it is likely that an ambulance would have been allocated to Miss J's call sooner had the original categorisation error not occurred. The Ombudsman upheld the complaint. He also upheld the complaint about the Trust's handling of Miss J's complaint which had taken too long.

The Ombudsman recommended that the Trust should apologise to Miss J and her family for the failings identified and pay her £1,500 in recognition of the distress she had been caused. He also recommended that the Trust give further consideration to his professional adviser's comments about the disturbance of crew rest breaks. The Trust agreed the recommendations.
Case reference 201103345

August 2012 – Other – Welsh Ambulance Services NHS Trust
Mr D complained to the Ombudsman about the time taken by ambulance personnel to attend to his late mother following her collapse at home. It took 42 minutes for a

paramedic to attend and a further 22 minutes before an ambulance arrived to convey her to hospital. Sadly his mother later died in hospital as a result of a lack of oxygen to the brain. The Ombudsman's investigation found that there was an unreasonable and unacceptable delay in the attendance of the paramedic and ambulance. The investigation identified that there were a number of failures which contributed to the delay. These included a failure to follow the Trust's procedures and implement existing arrangements; a failure to identify and deploy appropriate resources and a failure to ensure staffing cover locally. The Ombudsman was also critical of the Trust's own investigation into the matter.

The Ombudsman upheld the complaint and recommended that the Trust provide explanations and an apology to Mr D and his family in addition to redress of £5,000. The Ombudsman was also minded to make a number of other recommendations of a systemic nature. However he had made such recommendations in an earlier investigation report and was satisfied that the Trust had either implemented these recommendations or were actively doing so.
Case reference 201101693

Quick fixes and Voluntary settlements

March 2013 – Other – Welsh Ambulance Services NHS Trust
Mr R complained that the Trust had tried to cover up and fabricate facts for the reasons why an ambulance was not available to take him to hospital. My office spoke to the Trust, which acknowledged that the response received by Mr R did in fact contain inaccuracies. The Trust then agreed to write to Mr R with an apology, addressing the issue of the inaccuracies.
Case reference 201204491