Appendix

Explanatory Notes

The figures relating to pre-October 2009[1] NHS restructure health bodies have been added to the relevant post-NHS restructure health body. As such, the figures for Hywel Dda Health Board (HB) also include the figures of complaints and investigations against the following former NHS Trusts and LHBs:

- Hywel Dda NHS Trust,
- Carmarthenshire NHS Trust,
- Ceredigion and Mid-Wales NHS Trust,
- Pembrokeshire and Derwen NHS Trust,
- Carmarthenshire LHB,
- Ceredigion LHB, and
- Pembrokeshire LHB.

Any reference to Hywel Dda HB should be taken to include the above bodies for those periods prior to the NHS reform in October 2009.

Sections A and B provide a breakdown of the number of complaints against Hywel Dda HB which were received and investigated by my office during 2010-2011.

Section C compares the number of complaints against Hywel Dda HB which were received by my office during 2010-2011, with the average for health bodies during this period. The figures are broken down into subject categories.

Sections D and E compare the number of complaints against Hywel Dda HB which were received and investigated by my office in 2010-2011, with the average for health bodies (adjusted for population distribution[2]) during the same period.

Section F compares the complaint outcomes for Hywel Dda HB during 2010-2011, 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 Hywel Dda HB's response times during 2010-2011, with the average response times for health bodies, and the average for all public bodies in Wales during the same period. Graph G relates to those investigations which were commenced and concluded during 2010-2011.

Finally, Section H contains the summaries of all reports issued in relation to Hywel Dda HB during 2010-2011.

In order to assist in measuring performance during 2010-2011, sections A-G also contain the relevant figures for 2009-2010, adjusted for population distribution.

[1] http://www.wales.nhs.uk/sites3/docmetadata.cfm?orgid=811&id=142936
[2] http://www.wales.nhs.uk/sitesplus/888/page/44764

A: Complaints received by my office

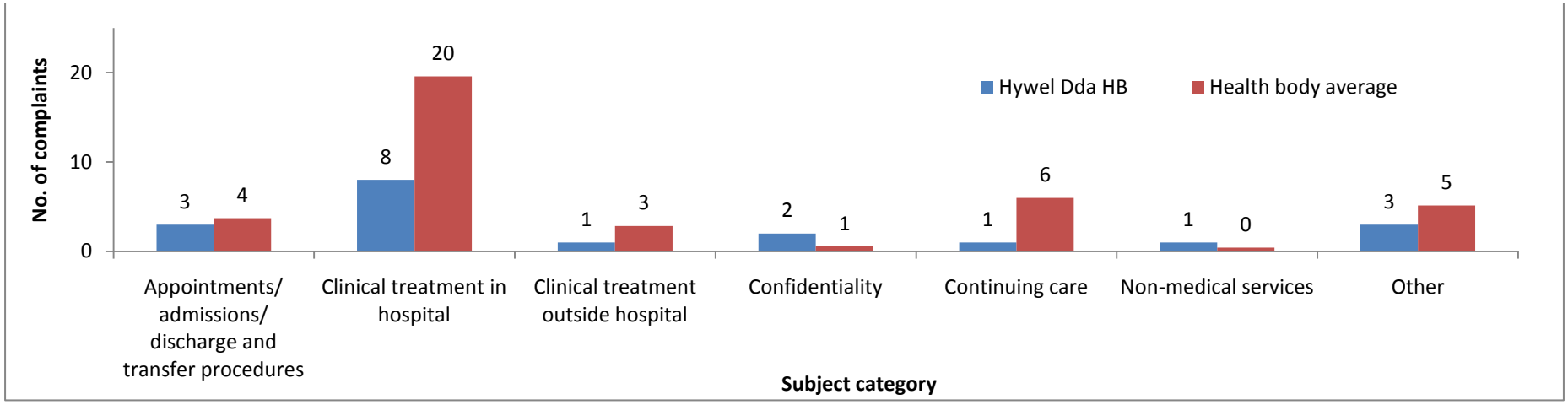
Subject	2010-2011	2009-2010
Appointments/ Admissions/ Discharge and transfer procedures	3	7
Clinical treatment in hospital	8	6
Clinical treatment outside hospital	1	1
Confidentiality	2	1
Continuing care	1	5
Non-medical services	1	1
Other	3	9
TOTAL	**19**	**30**

B: Complaints taken into investigation by my office

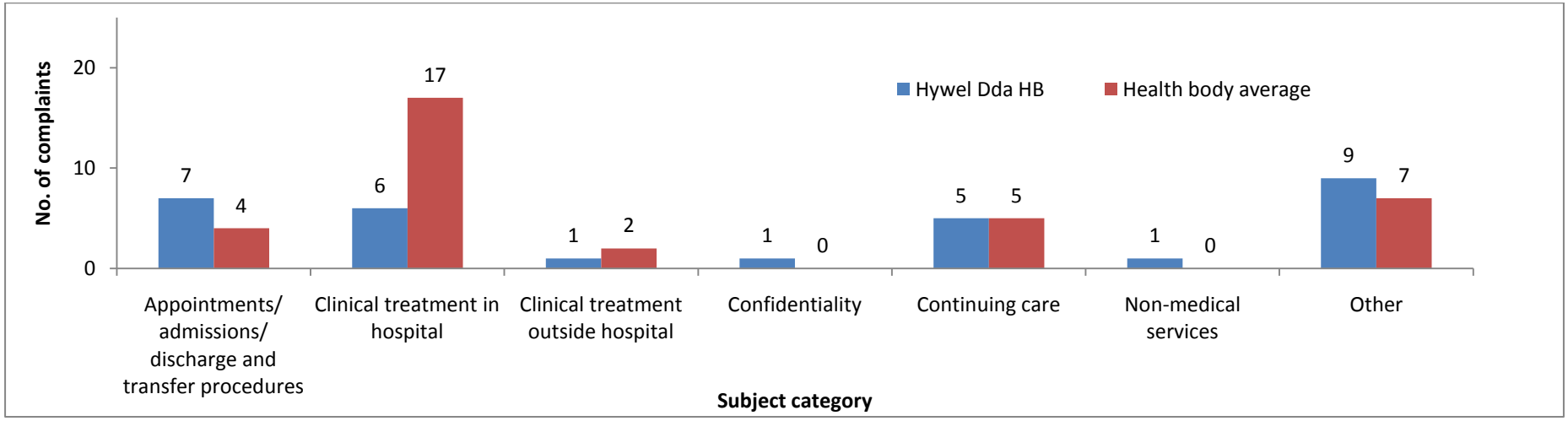
	2010-2011	2009-2010
Number of complaints taken into investigation	5	12

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

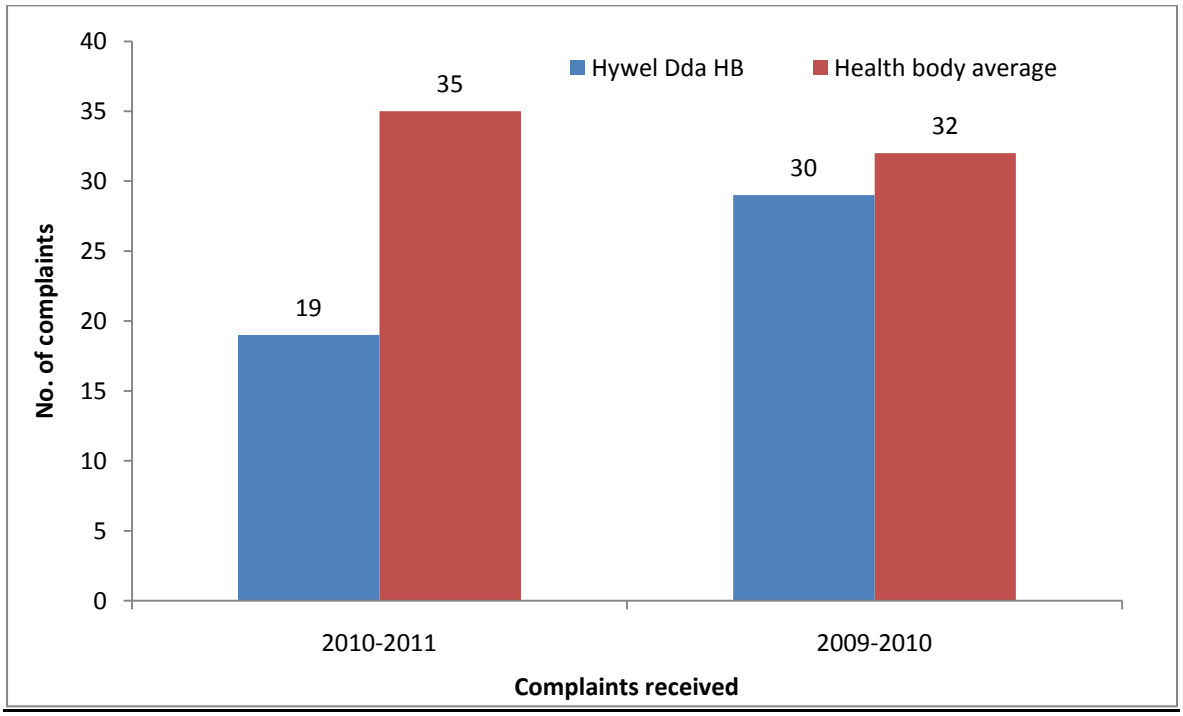
2010-2011



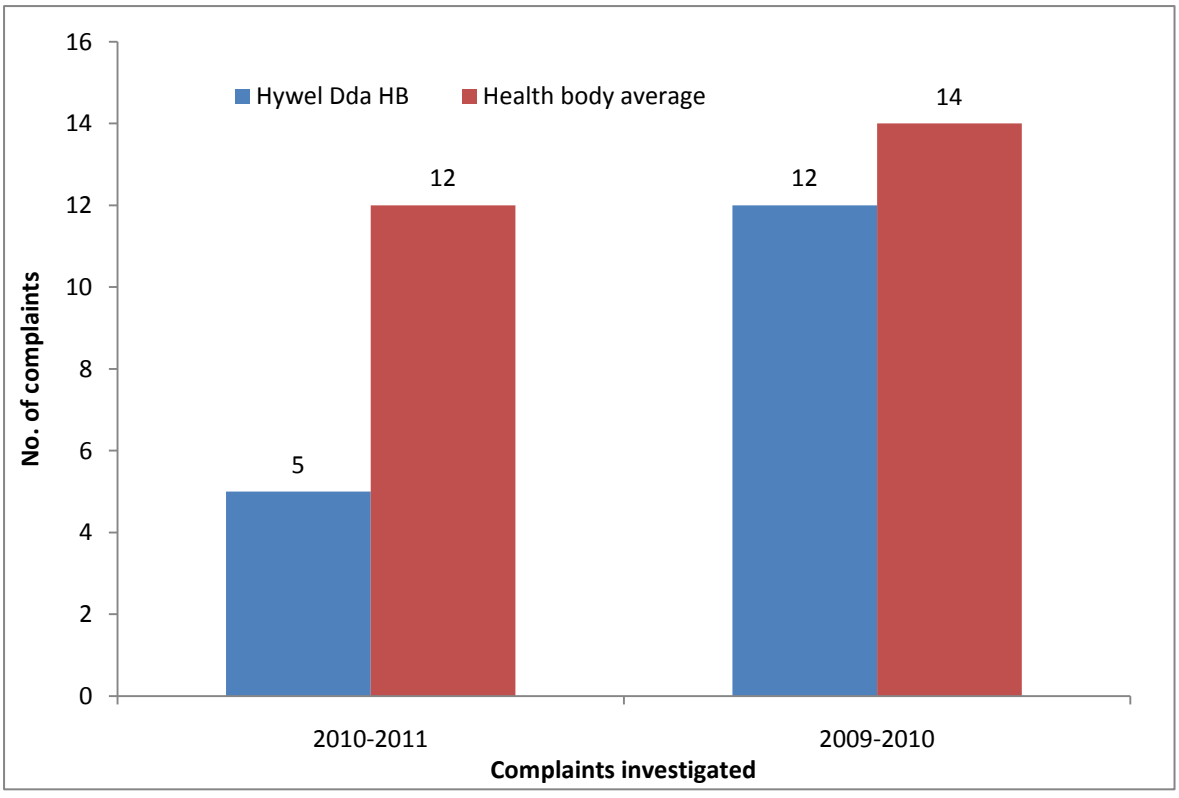
2009-2010



D: Comparison of complaints received by my office with average for health bodies

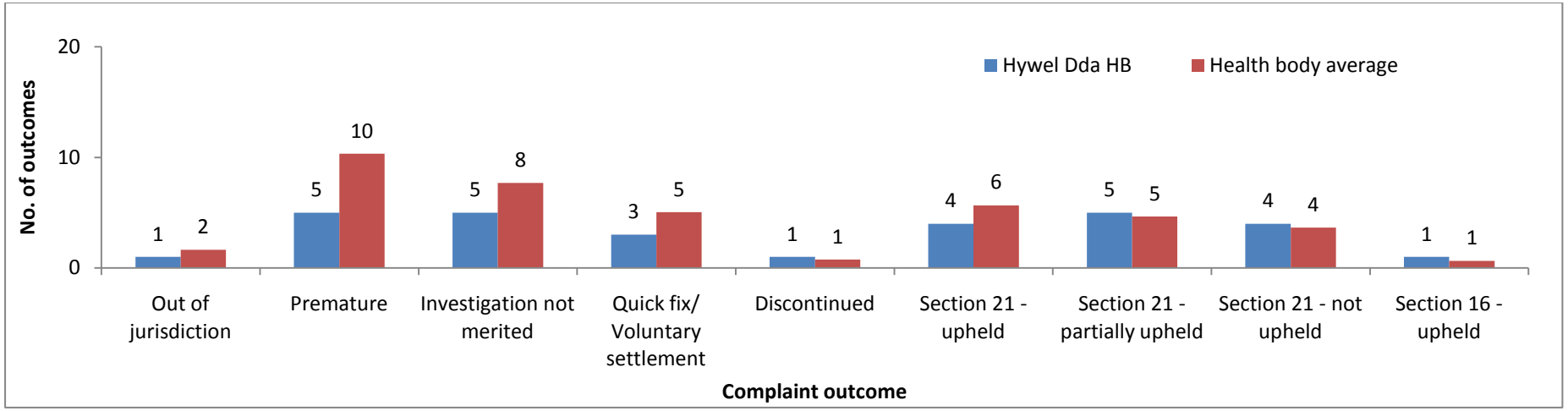


E: Comparison of complaints investigated by my office with average for health bodies

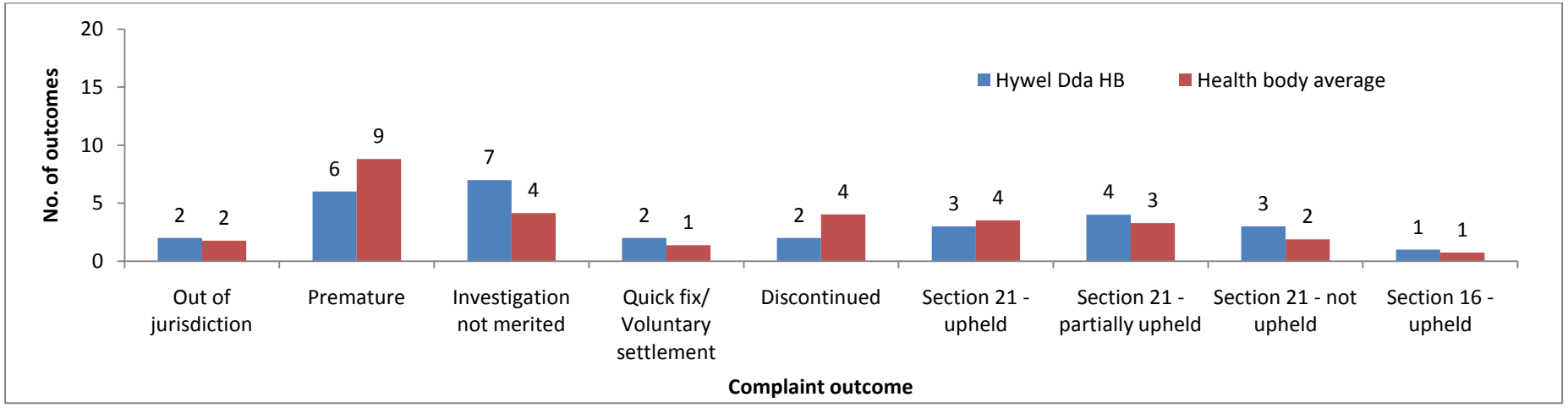


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

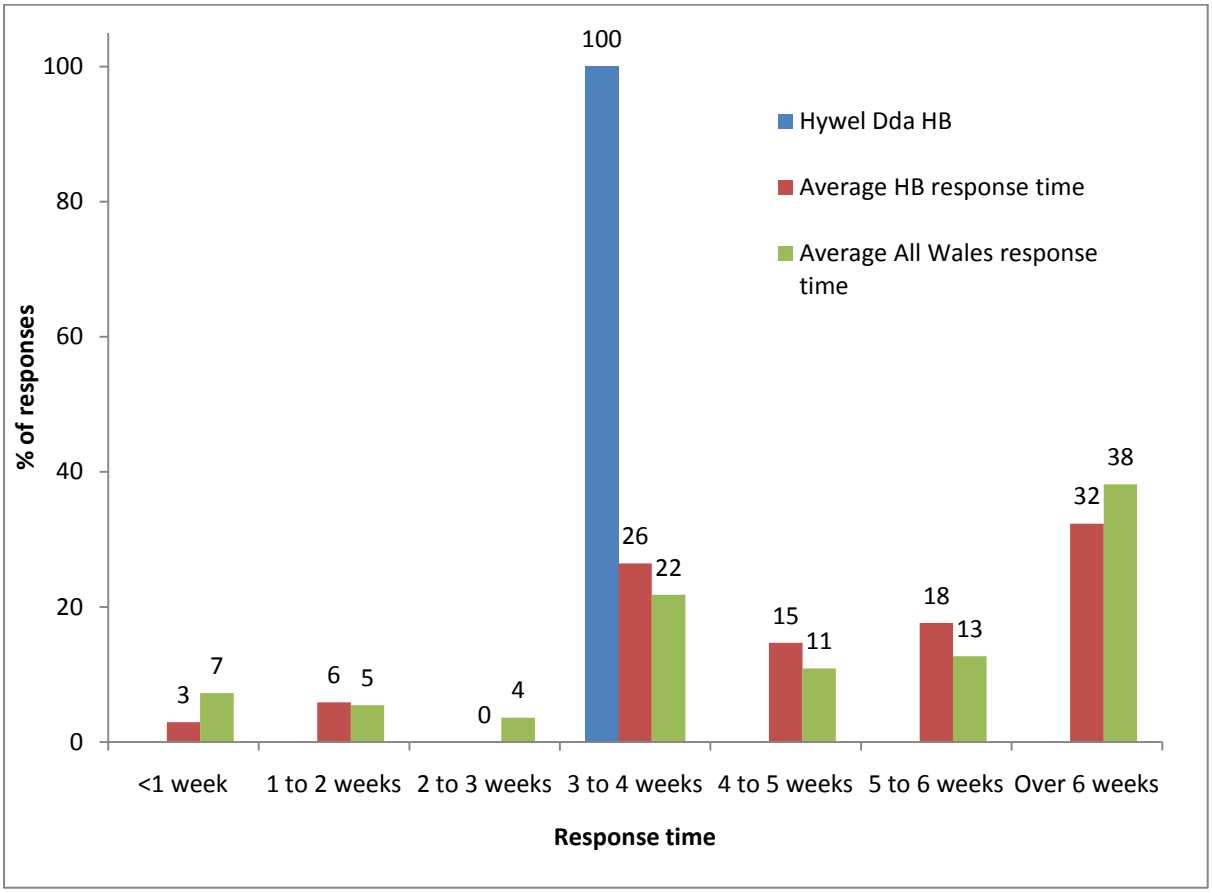
2010-2011



2009-2010



G: Comparison of Hywel Dda HB's times for responding to requests for information with average for health bodies and All Wales response times, 2010-2011



H: Report summaries

Health

The following summary relates to a public interest report issued under Section 16 of the Public Services Ombudsman (Wales) Act 2005.

September 2010 – Appointments, admissions, discharge and transfer procedures – Hywel Dda Health Board

Mr JL complained that his brother had been transferred between hospitals by taxi, without a nurse escort or oxygen and accompanied only by his wife. He complained that, due to the confusion caused by his illness and its treatment, Mr ML did not have the mental capacity to understand what the transfer entailed or to make an informed decision to agree to the transfer. He also complained that there was inadequate preparation or communication with Mr ML's family prior to the transfer taking place.

The Ombudsman found that Mr ML had not been properly assessed to establish whether or not he had the mental capacity to consent to the transfer and there was no record of any formal consent having been obtained from Mr ML. The Ombudsman also found that the medical records showed little evidence of any discussion with Mr ML or his family about the proposed transfer. The Ombudsman found that there was no evidence to suggest that Mr ML had been properly assessed as being safe to travel unescorted. The Ombudsman found that the record keeping in general was substandard, with documentation poorly completed by staff, if at all, on many occasions.

The Ombudsman also found that a Ward Sister had falsified an entry in Mr ML's medical records, more than a year after he had died. The Ombudsman concluded that this was done in order to conceal the fact that the Ward Sister had failed to notify Mr ML's wife of his proposed transfer the following day and also to make it look as though Mr ML's wife had agreed to accompany him on the taxi transfer. The Ombudsman found that the falsification of the entry in the medical records was a deliberate attempt to mislead and obstruct his investigation.

The Ombudsman recommended that the Health Board should formally apologise to Mr JL and his family for the failings identified in this report. The Ombudsman also recommended that the Health Board should carry out an audit of the standard of record keeping at Bronglais General Hospital and review its procedures for discharging and transferring patients.

The Ombudsman also recommended that the Health Board should review the care provided to Mr ML and thereafter consider whether further staff training was necessary. The Ombudsman recommended that the Health Board should remind all staff of the importance of ensuring that evidence provided to him during the course of an investigation is comprehensive and accurate. Finally, the Ombudsman referred a copy of his report to the Nursing and Midwifery Council in order that it could consider the conduct of the Ward Sister responsible for tampering with Mr ML's medical records.

Case reference 200901551

Health - Upheld

March 2011 – Clinical treatment in hospital – Hywel Dda NHS Trust (now Hywel Dda Health Board)
Ms A complained about the care and treatment she received in a hospital managed by the former Hywel Dda NHS Trust. The hospital is now managed by Hywel Dda Local Health Board ("the LHB"). Ms A complained about poor ward design; insufficient nursing staff available to attend to her care needs; faulty equipment which led to poor pain control; cleanliness of the ward and other infection control concerns; and that her discharge from the intensive care unit following her operation was too early. Ms A also complained about poor complaint handling.

The Ombudsman upheld several aspects of her complaint including that concerning the cleanliness of the ward, poor pain management and poor complaint handling. The Board recognised shortcomings in the ward's design and a complete refurbishment of the ward was undertaken. The Board also took steps to appoint additional staff. The Board agreed to apologise to Ms A, and pay her £100 for her time and trouble in pursuing her complaint as well as other action.
Case reference 200901949

February 2011 – Clinical treatment in hospital – Hywel Dda NHS Trust (now Hywel Dda Health Board)
A woman admitted to Withybush Hospital in November 2008 with shortness of breath and chest pain complained that her condition was not properly diagnosed in hospital and that she was discharged before tests (later carried out when she was an outpatient) were performed. She also maintained that the dosage of medication prescribed on discharge was inappropriate and that her condition had warranted an earlier referral to a heart specialist.

After taking clinical advice the Ombudsman found that the woman had been treated reasonably but that earlier referral to a cardiologist for possible cardioversion should have been considered. He considered that the arrangements for follow-up tests and review were not clearly explained to her but concluded that although the medication prescribed on her discharge subsequently needed review it had been appropriately prescribed. The Ombudsman also found some failings in the former Trust's handling of the woman's complaint. Hywel Dda Health Board agreed to consider when cardioversion might be used and to apologise to the complainant for the failings identified by the Ombudsman.
Case reference 200900849

December 2010 – Provision of services – Carmarthenshire Local Health Board (now Hywel Dda Health Board)
Mr X complained that the LHB had failed to provide Myalgic Encephalopathy/ Chronic Fatigue Syndrome (ME/CFS)-related services for his wife, Ms Y and her daughter, Ms Z. He said that it had no specialist services for persons affected by ME/CFS and that it had refused to fund treatment for Ms Y and Ms Z. He said that it had not given Ms Y any help and that the services it had offered her were unable to meet her needs. He also alleged that no one had followed Ms Z's treatment plan.

The Ombudsman did not uphold those aspects of Mr X's complaint that concerned the general provision of specialist services, the funding and provision of treatment for Ms Y and the implementation of Ms Z's treatment plan. He upheld that part of Mr X's complaint related to the LHB's refusal to fund treatment for Ms Z.

He recommended that the Health Board should consider amending its Individual Patient Commissioning ('IPC') Policy and its Policy and Procedure for CFS/ME. He asked it to make every effort to ensure that all clinicians are aware of their right to appeal against its funding decisions. He recommended that it should ensure that it keeps minutes of all its IPC Panel meetings and that these minutes accurately record the decision-making process. He asked it to make every effort to ensure that the IPC Panel considers all funding applications within one month of their receipt. He recommended that it should ensure that the IPC Panel has access to appropriate clinical expertise. He asked it to apologise, in writing, to Mr X and Ms Z, for the failings identified. He also recommended that it should pay Ms Z £750 to compensate her for its failure to meet her ME/CFS-related needs. The Health Board agreed to comply with these recommendations.
Case reference 200800465

November 2010 – Clinical treatment in hospital – Hywel Dda NHS Trust (now Hywel Dda Health Board)
Mr A complained that his partner Ms B was administered an anticoagulant drug and died following a large cerebral bleed. Mr A complained that the medical staff did not explain the risk of such bleeding associated with the anticoagulant treatment either to him or his partner and therefore considered that they had been denied their right to be involved in the decision making process. Mr A indicated that had the risks been explained that the treatment would have been refused. Mr A also raised in the complaint that an allergic reaction to antibiotic treatment may have been a contributory factor in Ms B's death. Mr A also complained about the way a doctor spoke to him prior to his partner's death.

The Ombudsman did not uphold the complaint about the clinical management of Ms B's condition including the administration of anticoagulant medication. However, the Ombudsman did uphold the complaint about the communication between the Health Board and Ms B's family and friends. He concluded that communication could have been improved particularly about the nature of Ms B's condition and the effects of anticoagulant treatment. He was unable to determine whether the doctor had been rude.

The Health Board agreed to implement the Ombudsman's recommendations regarding communication and the need for staff to be reminded of the rights of patients, family members and others in emergency situations.
Case reference 200802295

September 2010 – Continuing Care eligibility – Carmarthenshire Local Health Board (now Hywel Dda Health Board)
Mr H complained about the way the LHB considered his wife's eligibility for NHS continuing care funding. He also complained about the decision of the Chair of the LHB's continuing care independent review panel not to put his appeal before a panel

on the ground that Mrs H was so far outside the eligibility criteria for continuing care that a panel was not warranted.

The Ombudsman upheld Mr H's complaints. He found that Mrs H's multi-disciplinary team had not made a decision on her eligibility and that the paperwork it submitted to the LHB was incomplete. The LHB did not return the incomplete submission to the multi-disciplinary team, and the case was considered by the LHB's continuing care panel. The Ombudsman criticised the records of the continuing care panel as they did not adequately record the reasons for its decision.

The Ombudsman also criticised the way the Chair decided not to convene an independent review panel to hear Mr H's appeal. He found that the reasons given for the decision were inadequately recorded and did not appear to recognise the earlier failings in the way the application had been handled.

The Ombudsman recommended that Hywel Dda Local Health Board (as successor to Carmarthenshire LHB) should pay Mr H £200 to reflect the trouble he had been put to; properly re-assess his wife's eligibility for NHS continuing care funding and also reassess the other nine cases the Chair considered on that day. The Ombudsman also made some other procedural recommendations.
Case reference 200801759

September 2010 – Continuing Care – Carmarthenshire Local Health Board (now Hywel Dda Health Board)
Mr W complained about the way the former Local Health Board (LHB) had considered his mother's eligibility for NHS continuing care funding. He also complained that after he had appealed the LHB's decision, the Chair of the LHB's continuing care independent review panel decided that Mrs W was so far outside the criteria for NHS continuing care funding that a panel would not be convened to hear the appeal.

The Ombudsman upheld the complaint. He found that the LHB's original continuing care panel had considered the case despite the local multi-disciplinary team failing to complete all the necessary paperwork. The minutes of the two continuing care panels which considered the case were inadequate and the decision letters failed to give full reasons for their decisions. The Ombudsman found that the Chair's decision not to convene an independent review panel was also flawed as there was a failure to record adequate reasons for the decision both in the notes of the meeting and the decision letter. The Ombudsman recommended that Hywel Dda Local Health Board (as successor to the LHB) should pay Mr W £200 in recognition of the trouble he had been put to and review the other nine cases considered by the Chair on that day. He also made some other procedural recommendations.
Case reference 200801676

September 2010 – Continuing Care – Carmarthenshire Local Health Board (now Hywel Dda Health Board)
Mr C complained about the LHB decided that his mother was no longer eligible for NHS funded continuing care. He also complained that after he had appealed that decision, the Chair of the LHB's continuing care independent review panel decided

that Mrs C was so far outside the criteria for NHS continuing care funding that a panel would not be convened to hear the appeal.

The Ombudsman upheld Mr C's complaints. The Ombudsman found that the minutes of the continuing care panel which considered the case were inadequate and that the decision letter failed to give full reasons for the decision. He was critical of the fact that contrary to Welsh Assembly Government Guidance, Mrs C's continuing care funding was withdrawn before the appeal process was complete.

The Ombudsman found that the Chair's decision not to convene an independent review panel was also flawed as there was a failure to record adequate reasons for the decision both in the notes of the meeting and the decision letter. The Ombudsman recommended that Hywel Dda Local Health Board (as successor to the LHB) should pay Mr C £200 in recognition of the trouble he had been put to; reimburse the cost of the care home fees for the period Mrs C's appeal was ongoing; review her eligibility for NHS funded continuing care; and review the other nine cases considered by the Chair on that day. He also made some other procedural recommendations.

Case reference 200802583

September 2010 – Clinical treatment in hospital – Hywel Dda Health Board

Ms A complained about the care that she received whilst she was a patient at Withybush General Hospital. She suggested that the Trust did not use surgical stockings or adjust her arm sling properly. She said that a dressing applied to a cut on her nose was too large. She reported that the Trust did not identify or address her mouth injury. She said that it did not consider her dietary intake or requirements. She reported that female staff members were not always available to assist her with toileting. She said that staff members would not help her to get in or out of bed. She suggested that the Trust's communication with her, about her transfer options for rehabilitation, was poor. She reported that staff members would not return valuable items to her. She alleged that they bullied her. She suggested that they did not give her information about how to complain. She indicated that she was dissatisfied with the Trust's response to her complaint about these issues.

The Ombudsman upheld those parts of Ms A's complaint that concerned her mouth injury, her diet and her surgical stockings. He partly upheld those aspects of her complaint related to her nose dressing, her transfer options, the toileting assistance provided for her and the return of her property. He did not make any recommendations regarding these parts of Ms A's complaint for two reasons. Firstly, the Trust had acknowledged its failings and apologised for them. Secondly, it had already taken reasonable steps to address them. The Ombudsman did not uphold those parts of Ms A's complaint which concerned the attitude of staff members towards her, the adjustment of her sling, her inability to use her bed, the provision of information about making a complaint and the Trust's complaint handling.

Case reference 200802018

May 2010 – Administrative failure in appointments and admissions procedure - Hywel Dda NHS Trust
Mr C complained that there had been unreasonable delay in carrying out his hernia operation. He complained that he had been on the waiting list for two years, and that his operation had been repeatedly deferred for no valid reason. He claimed that the Trust's Waiting List Office (WLO) had lied to him. Mr C also complained that following a pre-operative assessment in March 2009 he was passed fit for surgery on the basis of a blood pressure reading that had been cleared by a Consultant Anaesthetist without seeing either Mr C or his notes. Mr C said that when he subsequently arrived for his operation in April 2009, it was cancelled because his blood pressure was deemed too high to proceed.

The Ombudsman found that there had been a number of administrative failures in the way the Trust managed Mr C's place on the waiting list. He was critical of the fact that the Trust did not chase another hospital more often for records that were needed to assess whether Mr C was fit for surgery; that after these records were received there was a long delay between subsequent appointments being offered; that when Mr C was offered appointments that were inconvenient for him there was not always evidence to suggest alternative dates were discussed with him; that he was wrongly told after elbow surgery that he could not have a general anaesthetic for three months; and that he was advised to contact his GP Practice for tests when the Practice could not do them. These are all examples of maladministration which caused Mr C an injustice as in all probability they meant he had to wait longer for his operation than should have been the case. The Ombudsman upheld this part of the complaint. He recommended that the Health Board (as it now is) apologise to Mr C and pay him £500 to reflect the distress and inconvenience he had been caused. He also recommended a number of measures to reduce the likelihood of the problems happening again.

The Ombudsman did not uphold the complaint about the operation being cancelled in April 2009. While with hindsight it may have been better if Mr C had been assessed by an anaesthetist at the pre-operative assessment, the Trust had complied with national guidelines and at that point Mr C's blood pressure was at a level where it was reasonable to proceed. Unfortunately, on the day of the operation Mr C's blood pressure was higher, and it was clinically reasonable for the operation to be cancelled given the risks that this might entail. The Ombudsman did not uphold this part of the complaint.
Case reference 200900831

Health - Not Upheld

June 2010 – Continuing care - Former Carmarthenshire Local Health Board
Mrs L complained that the former Carmarthenshire Local Health Board delayed unreasonably in conducting a retrospective review of her late mother's eligibility for fully funded continuing NHS health care. She also complained that the former LHB failed to comply with her request for access to her late mother's medical records which she required to defend legal proceedings brought by the local social services authority to recover the costs of late mother's nursing home fees. She claimed that as a consequence, she became liable for costs incurred by the local authority in obtaining a court order relating to the production of documents. She also claimed

that as a result of the LHB's delay in completing the review, the legal proceedings were protracted and led to an escalation of solicitors' costs.

Mrs L's complaint was not upheld. Even if there was a delay in conducting the review, there was no injustice. The legal proceedings had been concerned with recovering other charges which did not involve the LHB, and may therefore, have been brought in any event. Furthermore, Mrs L had been given ample warning of the local authority's intention to commence proceedings, but she did not ask the LHB to undertake a retrospective review until after the legal proceedings had been brought. Finally, I concluded that the LHB dealt with her informal requests for access to her late mother's medical record in a reasonable way. When her solicitors eventually made a formal request for access on her behalf, the LHB dealt with the request within the relevant statutory timescale.

Case reference 200900486

April 2010 – Clinical treatment in hospital - Hywel Dda NHS Trust

Mrs B complained that a shoulder injury was not diagnosed following a fall in February 2006. She was concerned that despite attendance at A&E and subsequent appointments with an orthopaedic consultant, a tear in her shoulder muscles was not identified until April 2007 following referral for an MRI scan. She complained that she paid for the scan and the corrective surgery privately because of waiting times for the treatment.

The Ombudsman did not uphold Mrs B's complaint. His advisers found that the treatment at A&E was appropriate for Mrs B's presenting injuries following her fall. Mrs B's attendances at the orthopaedic clinic were related to other historic injuries (mainly concerning her elbow) which were being looked into. Referrals were made for further tests on her elbow during this period. There was no mention in the orthopaedic clinic notes of specific discussions of her shoulder injury until a consultation in November 2006 when she was referred for manipulation of the shoulder under anaesthesia. The advisers could find no specific evidence that Mrs B should have been referred for an MRI scan, which would have identified the tear, at an earlier point.

Case reference 200801531