Meeting Date	**26 January 2021**	**Agenda Item**	**2.3**
Report Title	**Public Health Service Ombudsman Public Report**		
Report Author	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services		
Report Sponsor	Christine Williams, Interim Director of Nursing & Patient Experience		
Presented by	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services		
Freedom of Information	Closed		
Purpose of the Report	This report provides the Committee with a Public Service Ombudsman Public Interest Report and sets out the recommendations for the Health Board.		
Key Issues	The key issues to note: • The Public Service "Ombudsman" has upheld an investigation and issued a Public Interest Report as he is of the opinion the report provides the opportunity for learning across NHS Wales.; • Nine recommendations have been made by the Ombudsman for the Health Board to improve services/processes; • All recommendations have to be completed within 9 months.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☐	☐	☐

Recommendations	Members are asked to note the contents of the report and to receive an update report against the recommendations made in June 2021 and October 2021.

PUBLIC SERVICE OMBUDSMAN - PUBLIC INTEREST REPORT

1. INTRODUCTION

The Public Service Ombudsman "Ombudsman" has issued a Public Interest Report to the Health Board under the Public Service Ombudsman Wales Act 2005. This report sets out the findings of the report and the recommendations made to the Health Board. The report is attached as Appendix 1.

2. BACKGROUND

The Ombudsman may publish a report prepared under section 16 of the Public Service Ombudsman Act 2005 (4) if, after taking account of the interests of the person aggrieved and any other persons he thinks appropriate, he considers it to be in the public interest to do so. In this case the Ombudsman considers there are opportunities for learning to be shared across NHS Wales and has published the report on this basis.

OMBUDSMAN INVESTIGATION

The patient was under observation for Barrett's Oesophagus, and developed a lower oesophageal cancer, on the background of Barrett's. His care was transferred from Mr M in Singleton to the Princess of Wales Hospital and underwent his procedure under Mr H in early 2018.

Patient's wife felt that there was not any follow up/input or support provided to her and the patient until the end of August 2018 when he was reviewed by Mr M as Mr H had been on long term leave through July & August 2018.

Follow up care was to be provided by the Hospital the procedure took place in & POW advised that the CNS followed up with the patient regularly on the telephone & advised about nutrition.

The patient's wife has advised that they were not aware that her husband's prognosis was poor until the clinic appointment with Mr M on 29th August 2018. The patient sadly passed away on 14th September 2018.

A meeting was held with the family on 9th November 2018 and a response provided from Cwm Taf.

On review of this matter following receipt of the Ombudsman's investigation, the Health Boards confirmed that there are a number of failings in relation to the care provided to the patient, these include:

- Failure to initially refer the patient for Dietetic input pre-operatively
- The failure to provide psychosocial support to the patient and his wife
- Poor documentation of discussions with patient and his wife in relation to his poor prognosis
- A lack of ensuring that patient and his wife fully appreciated patients' poor prognosis following surgery and the implications of this.

- Although the Upper GI Clinical Nurse Specialist provided regular input, it is evident that the discussions with patient and his wife over the telephone were not documented and that reviewing patients over the telephone is not as effective as reviewing a patient in clinic.
- Seemingly, the lack patient and his wife not being fully prepared for patients' deterioration and sad death.
- Patient and his wife being advised that the patient had non-curable cancer in the Outpatient Clinic appointment with Mr M on 31st August 2018 and the patient passing away within two weeks would have been very distressing for the family and I am very sorry that the relevant support services were not arranged and in place prior to this.

The Health Boards have both fully reviewed this matter to extract learning to ensure that actions are put in place to prevent this from occurring again. It is apparent that patient and his wife should have been advised of the patient poor prognosis following his surgery and that these discussions, and confirmation that patient and his wife fully understood the extent of the patient's prognosis, should have been fully documented within the medical notes.

The Health Boards confirmed that it is evident in retrospect that the patient and his wife were sadly not prepared for the patient deterioration and did not receive the appropriate support to manage their expectations following his surgery. It was also established that Palliative Care input was not instigated within a timely manner.

The outcome would not have been altered in this case, although the Health Board acknowledged that the patient and his wife would have received appropriate support, input and advice throughout his deterioration, which would have resulted in the patient and his wife being appropriately prepared for his sad death.

3. ACTIONS FOR THE HEALTH BOARD

The Ombudsman made the following recommendations to the Health Board:

Within 1 month of the date of this report, both Swansea Bay and Cwm Taf Morgannwg should:

(a) Provide an apology to the patients wife for the shortcomings identified in this report.

(b) Share this report with all staff throughout the relevant service areas, for them to reflect on the findings and conclusions.

Within 3 months of the date of this report, both Swansea Bay and Cwm Taf Morgannwg should:

(c) Review current practice on the recording of telephone support offered by the Specialist Nurse Service, to ensure that it is compliant with the NMC Code and standards on record keeping and remind all relevant staff of those standards.

(d) Conduct a random sampling Patient Opinion Survey to establish an understanding of patients' experiences of UGI cancer care. Repeat this survey a year later to establish whether there has been any improvement and, if any issues around communications are identified as prevailing, take further steps to address them.

Within 6 months of the date of this report both Swansea Bay and Cwm Taf Morgannwg should:

(e) Ensure that the first Surgeon, the second Surgeon, the Oncologist and the Specialist Nurse consider and reflect on my findings as part of their regular supervision.

(f) Implement compulsory training for all doctors and nurses treating and managing patients with gastro-intestinal cancer, covering advanced communication skills and the need for patient involvement in care, including exploring patients' expectations and values around their personal diagnosis and prognosis, as well as the human rights issues identified in this case.

(g) Take steps to ensure that patients with upper GI cancer have access to nutritional assessment, tailored specialist dietetic support and psychosocial support, in line with the NICE guidance.

Within 9 months of the date of this report:

(h) Swansea Bay should consider the care in this case through a process akin to that provided in the Complaints Regulations, to decide whether there is any qualifying liability arising from any harm that arose from any breach in the Health Board's duty of care as a result of the failings identified.

(i) Within 6 months of reminding relevant staff of the NMC standard of record keeping, both Swansea Bay and Cwm Taf Morgannwg should conduct an audit of a reasonable sample of Specialist Nurse records in the service, to determine the standard of compliance with NMC Code and take action to address any shortcomings.

4. NEXT STEPS

The Health Board has accepted the recommendations and confirmed to the Ombudsman that the recommendations will be completed by the deadlines set and confirmation will be provided to the Ombudsman once all actions have been completed.

5. RECOMMENDATION

To note the contents of the report and agree to receiving a report in June and October 2021 on progress against the actions in relation to the recommendations of the Ombudsman.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☐
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☐
	Staff and Resources	☐
Quality, Safety and Patient Experience		
No proposal for the Committee to consider.		
Financial Implications		
No implications for the Board to be notified of.		
Legal Implications (including equality and diversity assessment)		
No implications for the Board to be notified of.		
Staffing Implications		
No implications for the Board to be notified of.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
No implications for the Board to be notified of.		
Report History	Last Public Interest Report issued in February 2020	
Appendices	Appendix 1 – Public Services Ombudsman Public Interest Report	