Meeting Date	**01 October 2021**	**Agenda Item**	**5.1**
Report Title	**Public Service Ombudsman Annual Letter**		
Report Author	Erica Thomas Howells, Ombudsman Lead		
Report Sponsor	Gareth Howells, Executive Director of Nursing		
Presented by	Gareth Howells, Executive Director of Nursing		
Freedom of Information	Open		
Purpose of the Report	This report updates the Board with the Public Service Ombudsman Annual Letter for Swansea Bay University Health Board for the period 2020/21.		
Key Issues	The Annual Letter highlights: • There has been a decrease in the number of cases referred to the Ombudsman during the reported period of 2020/21 (79) compared to 2019/20 (91) • A decrease in the number of complaints which proceeded to investigation 2019/20 (31) when compared to 2020/21 (25) • There has been a slight increase in complaints regarding clinical treatment in hospital compared to 2019/20, this is only a difference in 3 complaints from the previous year. • There has been a 50% decrease in complaints regarding complaint handling compared to the previous year. Action being taken to improve and learn from complaints includes: • Concerns Assurance Manager taking a lead in terms of ensuring timely responses are sent to the Ombudsman. • Training programme in place to share the learning from Ombudsman cases and findings following the Concerns, Redress & Assurance Group (CARG) following a review of closed complaint responses. • Complaints Standards Training delivered by Ombudsman		

Specific Action Required	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☐	☐	☒

(please choose one only)				
Recommendations	The Board is recommended to: • **NOTE** the contents of the report and actions being taken to improve complaint management and learn from the Ombudsman cases.			

Public Service Ombudsman Annual Report

1. INTRODUCTION

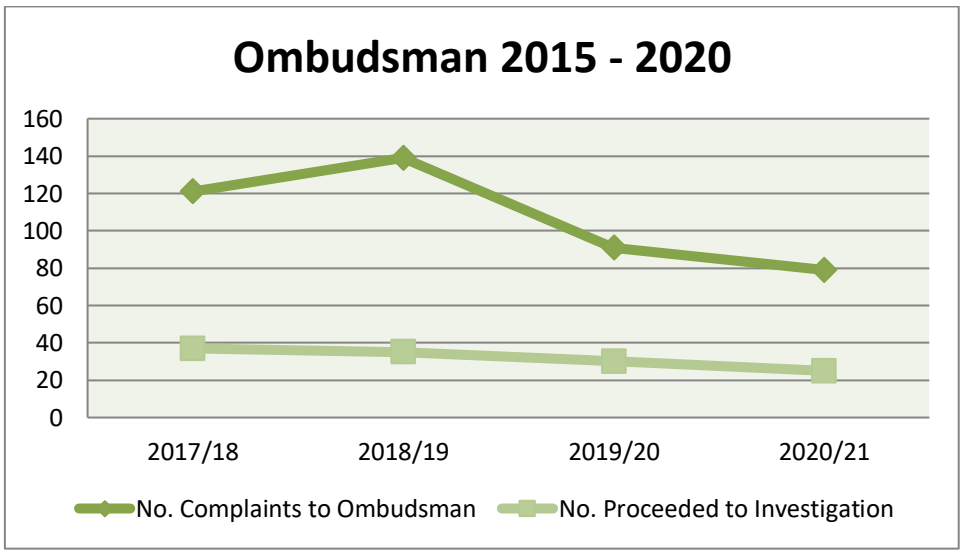
This report provides the Board with the Public Service Ombudsman Annual Report in relation to complaints referred to the Ombudsman during 2020/21.

2. BACKGROUND

The Public Service Ombudsman provides an Annual Letter, attached as **Appendix 1**, to each Health Board in Wales. On this occasion it also contains the Annual Report and Accounts data, which has allowed the Health Board to analyse its performance in comparison with other Health Board's in Wales.

3. GOVERNANCE AND RISK ISSUES

There has been a decrease in the number of cases referred to the Ombudsman during the reported period of 2020/21 compared to 2019/20



	2017/18	2018/19	2019/20	2020/21
No. Complaints to Ombudsman	121	139	91	79
No. Proceeded to Investigation	37	35	31	25

4. Public Service Ombudsman's Annual Letter

The Ombudsman Annual Letter was received on 1st October 2021 and advises that the past year has been an unprecedented time for public services in Wales. The Annual Letter advises that it discusses information from a year unlike any other in recent memory, and as such may not be useful for establishing trends or patterns.

During the past financial year, the Ombudsman has intervened in (upheld, settled or resolved at an early stage) the same proportion of complaints about public bodies, 20%, compared with 2019/20.

Last year, there was a 22% reduction in new complaints relating to Health Boards – a predictable reduction given the circumstances of the year. However, the Ombudsman's Office intervened slightly more frequently in complaints involving Health Boards, 33% compared to 31% in 2019/20.

The Ombudsman advises that the Health Board continues to actively and positively engage with our Improvement Officer, with prompt and candid responses from the Liaison Officer when contacted for assistance. The Ombudsman was encouraged by the Health Board's continued commitment to learning, for example, by regularly inviting our Ombudsman Improvement Officer to present to newly-qualified Consultants as part of their professional development programme, and in engaging with training sessions with the Ombudsman's Complaints Standards Staff.

5. Ombudsman Process

We monitor the new Ombudsman cases as part of our monthly performance review of data and undertake an analysis of themes and trends. We have noted that communication and complaints handling is a common theme throughout the Health Board, and often the only part(s) of an Ombudsman concern which is upheld when we receive the final Ombudsman report.

The Ombudsman delivered Complaints Standards training to all Quality & Safety Teams within the Units and have advised that they have already seen great benefits from this work, including the standardisation of complaints data recording.

6. Public Interest Reports (Section 16)

The Health Board has received two Section 16 Public Services Ombudsman for Wales Report during the year 2020/21.

1st Public Interest Report - Morriston & Singleton Hospital

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 a Consultant Surgeon in Singleton to the Princess of Wales Hospital and underwent his procedure in early 2018.

The patient's wife advised that there was not any follow up/input or support provided to her and her husband until the end of August 2018 when he was reviewed his original Consultant in Singleton as the Surgeon in the Princess of Wales (POW) 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 Clinical Nurse Specialist followed up 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 the original Surgeon in Singleton Hospital 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 University Health Board.

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 included:

- Failure to initially refer the patient for Dietetic input pre-operatively
- The failure to provide psychosocial support to the patient & his wife
- Poor documentation of discussions with the patient & his wife in relation to his poor prognosis
- A lack of ensuring that the patient & his wife fully appreciated the patient's 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 the patient & 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 of support and information provided by the Health Board resulted in the patient & his wife not being fully prepared for his deterioration and sad death.
- The patient & his wife being advised that he had non-curable cancer in the Outpatient Clinic appointment with the Consultant Surgeon on 31st August 2018 and he patient passing away within two weeks would have been very distressing for the family

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 the patient & his wife should have been advised of the patient's poor prognosis following his surgery and that these discussions, and confirmation that the patient & 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 & his wife were sadly not prepared for his 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 & his wife would have received appropriate support, input and advice throughout his deterioration, which would have resulted in them both being appropriately prepared for his sad death.

The Ombudsman has advised that they issued a Section 16 Report in this matter due there being:

- Evidence of service failure which has caused injustice.
- It is appropriate for the Ombudsman to consider whether a person's human rights may have been engaged and/or compromised as a result.
- Given the patient's evidence in describing her husband's deterioration, and the effects of that experience without adequate or appropriate advice and support, I think that both the patient and his wife's human rights were likely to have been compromised in this case.
- They should have had the information and support to enable them to receive appropriate care when the patient had symptoms of recurrence.
- They should also have had the time to come to terms with the patient's prognosis and to prepare for his eventual outcome both mentally and with suitable palliative care aids and support.
- The fact that they did not impacted on the patient's rights as an individual, and on both the patient and his wife's rights as part of wider family life.
- This is particularly important at the end of someone's life and the failures identified therefore represent serious injustices to both the patient and his wife.

2nd Public Interest Report – Mental Health & Learning Disabilities

The patient was admitted to a Learning Disabilities Unit on 6th March 2017. The patient's self-injurious behaviour was historical, intense and ongoing since childhood. A Positive Behavioural Support Care Plan was in place during her time in the Unit. This was provided by her previous placement in order to support her transition to her new placement.

The patient's Positive Behavioural Support Care Plan was updated whilst at the Unit and she had Multi-Disciplinary input from Medical staff, Nursing staff and Psychologists. Her Clinical Psychologist, had cared for the patient since she was a child and also offered input to the Positive Behavioural Support Care Plan.

The patient injured herself daily and the Positive Behavioural Support Care Plan relayed this information. Her key behaviours include verbal & physical aggression, self-injury, non-compliance, property destruction, ritualistic behaviours and socially inappropriate behaviours.

The patient's presentation of self-injurious behaviour is listed as:

- Tapping her face – no injury.
- Slapping her face – leaving a red mark.
- Punching her face – leaving red marks, bruising and swelling. This has only occurred once whilst the patient was on Section17 leave from hospital.
- Head banging back or side of head against the wall – no notable injuries visible to date as usually brief and can be distracted quickly.
- Head banging front of head against the wall - no notable injuries visible to date as again this is usually brief and distraction is successful.

The above behaviours are documented as occurring and presenting in a random cycle. They could occur at any time during the day and there does not appear to be any obvious pattern other than the patient becoming overwhelmed or distressed.

- The self-injury appears repetitive in nature and intensifies as her level of distress increases i.e. starts with a tap and progresses to slapping and occasionally punching.
- It is believed that the patient has a pain/damage threshold and that she does not cross this – however she has caused herself significant injury when her mental health was very poor.
- The patient will engage in self-injurious behaviours during her morning routine on a regular basis and whilst engaging in other demand based routines.
- It is known that the patient can display high levels of self-injurious behaviours when she goes to new settings likely due to an increased level of anxiety at being in an unfamiliar place wand with routines and staff she doesn't fully understand.

Staff would intervene physically if higher intensity self-injury occurred. Each time the patient displayed self-injurious behaviour, she was checked over by both nursing and, if indicated, medical staff. This was in order to ensure that the patient did not require further medical input for any injuries she may have sustained as a result.

The patient's Positive Behavioural Support Care Plan documents that self-injurious behaviour was a daily occurrence. She mostly had some bruising and swelling to her face and this was normal for the patient due to her slapping and hitting herself up to 40 times per day.

Initial Investigation

The Lead Manager, Learning Disabilities, & Consultant Learning Disabilities, initially confirmed that there was not a delay in diagnosis of the patient's eye condition. When the nursing staff raised concerns regarding the patient's eye on 10th September 2018, she was reviewed by the Specialist Trainee Doctor, who felt that she had a cataract in her right eye due to a difference in colour/shade of her eye and felt that she required a review at an Opticians. These findings were escalated her findings to the Consultant, who was concerned that the patient may have sustained a detached retina due to the development of a traumatic cataract.

The patient was reviewed at the University Hospital of Wales, Cardiff, Ophthalmology Department on 12th September 2018 by the Consultant Ophthalmologist, who confirmed that she had sustained a total right eye retinal attachment and that surgery would be unlikely to restore her sight. He opined that, due to the complexities of the patient's behaviour, she would not be able to cope with surgery and particularly the aftercare required.

Yearly eye assessments were recommended for the patient and this was handed over to her new placement on her discharge. The medical notes document that the patient was experiencing some off baseline behaviours on and around the 7th, 8th and 9th August 2018. This included hitting out, kicking and biting staff, head banging, slapping and throwing her meals when served.

Staff initially confirmed that had there been no concerns regarding any changes to the patient's eye prior to the 10th September 2018, and if there had been, they would have sought an immediate medical review, which was requested as soon as a change in the patient's eye became apparent.

Further enquiries sent from Ombudsman following receipt of the initial investigation advised that there was a concern raised regarding the patient's eye in June 2018, and given that the patient's pupils were noted to be dilated and uneven on two occasions, with a grey shadow noted on her right eye, there was nothing contained within the records to show that this was monitored or resulted in a medical review.

The opinion of the Consultant Ophthalmologist in UHW that the injury occurred 2 weeks prior to her review in UHW (in September 2018) provided false assurance in this case to the Unit as the issue the Ombudsman had concerns regarding was in June 2018 when the notes advise the patient had a grey mark on her eye and that it was to be monitored – the notes document monitoring of this for a few days and then there is no mention of it (they felt that it was the start of a cataract from her self-injurious behaviour and were certain if something still remained on her eye that it would have been mentioned & escalated like it was in August 2018) and therefore felt it was a documentation issue, for which the Health Board offered £250 ex-gratia payment for the poor documentation.

The Ombudsman has advised that they issued a Section 16 Report in this matter due there being:

- The Health Board's investigation failed to identify that the patient's eye care in June 2018 fell far below the standard expected from healthcare professionals. The Health Board told the complainant and the Ombudsman that, up until 10 September, staff had not been concerned about the patient's eyesight. This was clearly not the case, when records indicated that in June 2018 there was an issue identified with the patient's eye.
- Although it is possible that the patient's retinal detachment occurred in June, the Ombudsman could not say with any certainty that an earlier referral for

ophthalmology advice would have resulted in a different outcome. Nevertheless, the failure to monitor the patient's eye or refer for specialist advice in June was a service failure and furthermore was not in line with the NMC Code requirement to provide fundamentals of care.

- The Ombudsman advised that the patient was a vulnerable young adult, who was denied the opportunity of a timely referral and clinical review and this was an injustice.
- It is also apparent that communication with the patient's mother regarding the patient's eye condition was inadequate and the records do not support that the Unit kept her updated. This was a serious communication failure and meant that when the complainant received a telephone call in September to advise her of the situation regarding the patient's eye, it came as a shock to her and caused her alarm. The failure to inform the patient's mother of these concerns caused her distress and was an injustice to her.
- In addition, the uncertainty about the outcome is a significant injustice to the patient who did not receive an appropriate level of eye care. It is also a considerable injustice to the complainant as there will always be an element of doubt about whether the outcome could have been different for the patient who ultimately lost sight in her right eye.
- It is recognised that individuals who are in institutional care settings are amongst the most vulnerable in our society and are amongst the most vulnerable to having their human rights compromised. It follows that there is an extra level of responsibility on public bodies to ensure that policies and practices respond appropriately to the needs of the vulnerable (both corporately and by individuals).
- The failing in this case, in my view, engages the patient's Article 8 rights. The Health Board had not sufficiently demonstrated that it ensured the needs of an adult with a learning disability, such as the patient who was unable to effectively articulate her vision problems, were sufficiently respected.

6. Current position

Between the 1st April 2021 to 30th September 2021 the Health Board received 9 new Ombudsman investigations compared to 6 for the same period in 2020.

As of the 7th October 2021, there are currently 31 open Ombudsman cases:

Service Delivery Unit	No of Ombudsman Cases Currently open
Morriston Hospital	11
Primary Care & Community **(these 4 are not current Health Board investigations as they involve 3 GP Practices and 1 Dental which the Health Board oversees)**	4
Singleton NPT Service Group	11

Mental Health & Learning Disabilities	5
Total	**31**

Of these 31 cases:

- 3 new investigations
- 17 awaiting the outcome of the Ombudsman's investigation
- 3 investigations are at draft reporting stage
- 6 at formal reporting stage with actions for implementation
- 2 cases awaiting confirmation of compliance

7. Work to reduce the number of cases which require Ombudsman intervention

The Health Board's Concerns Assurance Manager is a dedicated full time lead resource with responsibility for Ombudsman cases and complaints, as well as ensuring a culture of learning and improvement is conveyed throughout the Service Delivery Units within the Health Board. The Concerns Assurance Manager has ensured that all Ombudsman timescales are met to ensure continued timeliness when communicating with the Ombudsman. The Health Board has Key Performance Indictors in place, which are monitored on the Datix system, which assist with achieving the timescales set by the Ombudsman. The Health Board is pleased to be successfully responding to the Ombudsman within the prescribed timescales and very rarely requiring extensions. If an extension is required, usually due to clinicians being on leave or to request an extra day for sign off due to the unavailability of the Executive Team for signing, we liaise closely with the Ombudsman handler to agree.

The Concerns Assurance Manager has put in place an Ombudsman Project Plan, which includes a tailored training programme to provide Ombudsman Learning and Assurance training, based on identified themes and trends, to each of the Service Delivery Units. The training will also incorporate the importance of complying with actions agreed at meetings with complainants and in complaint responses. This will ensure a robust system is in place in the Service Delivery Units.

8. Working on Upheld and Partially Upheld Complaints

The Ombudsman Improvement Officer has advised that the Health Board has a high amount of complaints which are upheld and partially upheld. The Concerns Assurance Manager is currently compiling training for the Units on the themes and trends identified by the upheld portions of complaints. Complaints can be solely upheld on complaints handling issues and we are working closely with the Units to provide advice and support regarding this. Tailored training will also be delivered to the Governance

and Quality & Safety Teams. The current theme which is being assessed is the upholding of complaints regarding communication and also Human Rights.

9. Concerns Redress Assurance Group (CRAG)

On a monthly basis, the Health Board conducts a Concerns Redress Assurance Group (CRAG) where the Corporate Complaints Team review recently closed complaints. Each month a 'deep dive' review is undertaken on each Service Delivery Unit in turn, as well as the review of a selection of closed complaints from the other Service Delivery Units. During this review, any agreed actions by the Service Delivery Units are monitored by the Corporate Complaints Team to confirm actions are completed to ensure compliance. CRAG commenced in 2016 and is continually developing and evolving to ensure that the best possible learning and assurance is attained by the Health Board. The Health Board has also introduced CRAG workshops where learning is shared with senior members of the Service Delivery Units. All complaint responses that are reviewed through the CRAG process are considered in terms of whether the Service Delivery Unit has answered the complaint in full, the handling of the complaint and if it was in accordance with the Regulations. Feedback and support is provided to each Service Delivery Unit through the CRAG process.

The CRAG reviews have indicated:

- Communication
- Poor Concerns Handling/ Delays/Communication
- Clinical Treatment
- Pain Management
- Poor Record Keeping
- RTT
- Consent

10. Patient Experience and Feedback

We continue to actively seek feedback from patients and their families to ensure that we fully capture their experiences of care and are able to assess themes and trends via Friends and Family surveys, Feedback Forms and Patient Experience Digital Stories which are all shared with the Service Delivery Units, used for training purposes and presented at Quality and Safety Group meetings.

11. Persistent / Vexatious Complainants

The Health Board currently deals with high-risk, often persistent and vexatious complainants corporately to assist the Units. If a complainant has their concerns considered by the Ombudsman, complainants, who tend to send vast amounts of communications to the Health Board, often copy the Ombudsman into the emails and

letters. We then provide updates to the Ombudsman regarding progress of these cases for them to remain fully informed of the Health Board's management.

12. Continue to work with the Improvement Officer to improve complaint handling and the Health Board's response times

The Health Board has worked closely with the Improvement Officer in the past 12 months. Steve Brisley, Improvement Officer, has also attended and provided training within the Health Board and at the Consultant Training Programme.

We still currently have our Improvement Officer in place, although we are working closely with the Ombudsman Office to ensure we are compliant and timely with all requests and timescales.

13. Early Resolution

The Health Board is keen to ensure that enquiries and new referrals received from the Ombudsman are considered for early resolution as this is a means of bringing cases to positive fruition by providing the Complainant with a swift and appropriate outcome. One of the functions of the dedicated Concerns Assurance Manager is to review each enquiry and new referral on receipt to evaluate whether it is appropriate for it to be dealt with via early resolution. We have a positive rapport with each of the Service Delivery Units, which assists with clear and timely communication regarding cases suitable for early resolution.

We have had success with early resolutions in the form of:

- Meetings between the Complainant & Specialty.
- Re-opening concerns for investigation.
- Making offers under Redress.
- Ex-gratia payments for poor concerns handling.

Early resolutions preclude the requirement for a full Ombudsman investigation, so are a positive outcome for the patient, Ombudsman and the Health Board. Steve Brisley has advised that the amount of early resolutions within the last year has increased, which is a positive outcome.

14. Proposed Actions:

- Continue working to the Ombudsman Key Performance Indicators to ensure continued timeliness.
- Tailored Ombudsman training/workshops for each Service Delivery Unit to reduce the number of cases which require Ombudsman intervention.

- Complaints Standards Training & Communication Training to be rolled out within the Units.
- Concerns Redress Assurance Group to continue reviewing and auditing complaint responses to ensure compliance with the Regulations.
- Appropriate early resolution to be considered on receipt of each Ombudsman enquiry and investigation.
- Concerns Assurance Manager attends all Welsh Risk Pool Ombudsman and Complaints Network meetings.
- Concerns Assurance Manager works closely with Primary and Community Care Service Delivery Unit to ensure consistency in the approach to cases which relate to the primary care setting.
- Tailored Mental Health & Learning Disabilities training is currently being arranged to reinforce the Putting Things Right Regulations and Redress process.
- Work currently being undertaken on how to provide training to the Units based on the outcomes and learning of the Public Interests (Section 16) Reports received by the Health Board.

15. RECOMMENDATION

The Board is recommended to:

- **NOTE** the contents of the report.

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		
Taking action to learn from patient experience and complaints aims to reduce the number of incidents/harm to patients in our services.		
Financial Implications		
No financial implications		
Legal Implications (including equality and diversity assessment)		
If complainants are not satisfied with their responses then they may pursue a civil claim.		
Staffing Implications		
No staffing implications.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
No implications.		

Report History	Previous updates have been provided the board.
Appendices	**Appendix 1 Public Service Ombudsman Annual Letter**